

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration**

HIV/AIDS Bureau
Division of Community HIV/AIDS Programs

***HIV Early Intervention Services (EIS) Program
Existing Geographic Service Areas (EISEGA)***

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FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2013

Application Due Date: January 29, 2013

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I. Funding Opportunity Description

1. Purpose

The Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) announces this funding opportunity for competing Part C Early Intervention Services (EIS) to support outpatient HIV early intervention and primary care services. These services target low-income, medically underserved people living with HIV/AIDS.

The purpose of the Ryan White HIV/AIDS Part C EIS Program is to provide HIV primary care in the outpatient setting. Applicants must propose to provide a comprehensive continuum of outpatient HIV primary care services in the targeted area including: 1) targeted HIV counseling, testing, and referral; 2) medical evaluation and clinical care; 3) other primary care services; and 4) referrals to other health services. Primary care for persons with HIV disease should start as early in the course of the infection as possible. However, entry into a Part C EIS program may take place at any point in the spectrum of the disease or the patient's lifespan.

As established in section 2651 of the PHS Act, and according to the terms and conditions of these awards, a Part C program grantee must expend grant funds to provide HIV primary medical care in a proposed service area. These services must be reflected in the budget. Staff positions such as nurses, medical assistants and dental hygienists can be included in the budget when the position proportionately complements HIV primary medical care providers, such as physicians, dentists, physician assistants, or nurse practitioners for the Part C program. Accordingly, a Ryan White HIV/AIDS program Part C budget must reflect a medical model of care in which providers can *assess, treat and refer*, as applicable. Providers must be authorized, via credentialing and licensure, to prescribe medications, order medically indicated tests/exams, interpret symptoms, treat, and meet HHS guidelines.

As established in section 2693 of the PHS Act, the Minority AIDS Initiative (MAI) is intended to address the disproportionate impact that HIV/AIDS has on racial and ethnic minorities and to address the disparities in access, treatment, care, and outcomes for racial and ethnic minorities, including African Americans, Alaska Natives, Hispanic/Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders. MAI funding is designated as part of the base award for applicants who meet the description below.

Minority AIDS Initiative (MAI)

The goal of the MAI is to help reduce the disproportionate impact of HIV/AIDS and address disparities by:

- Increasing the number of persons from racial and ethnic minority populations receiving HIV care, and
- Increasing the number of persons from racial and ethnic minority populations who stay in care.

MAI funds are granted to health care organizations that provide culturally and linguistically appropriate care and services to racial and ethnic minorities. Funded Part C EIS programs will be assigned funds under the MAI based on the data provided in the application by the

HRSA/HAB Division of Community HIV/AIDS Programs (DCHAP), which administers the Part C EIS program. The MAI assignment is based on the percentage of the population served or proposed to be served from racial/ethnic minority communities.

The amount of MAI funds awarded is noted under the grant specific terms section of the Notice of Award (NOA) which establishes the final funding for the budget period.

National HIV/AIDS Strategy (NHAS)

The National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. The NHAS also calls for improved federal coordination of HIV/AIDS programs, as evidenced by streamlining and standardizing data collection and reducing reporting requirements for grantees. Over the past year, the Office of HIV/AIDS and Infectious Disease Policy in HHS has worked with a group of Federal Agencies, National Partners and grantees to identify indicators, data systems, and elements used across HHS programs to monitor HIV prevention, treatment, care services. A set of common indicators is being implemented within 7 domains: 1) HIV testing; 2) Late HIV diagnosis; 3) Initial linkage to HIV medical care; 4) Retention/engagement in HIV medical care; 5) ARV Therapy; 6) Viral Load suppression; and 7) Housing Status. These indicators are covered under the Ryan White HIV/AIDS Program Services Report (RSR) that grantees and service providers report to HRSA on an annual basis, and thus HRSA/HAB will be positioned to calculate and report on these indicators.

Part C programs should comply with Federally-approved guidelines for HIV Prevention and Treatment (see <http://www.aidsinfo.nih.gov/Guidelines/Default.aspx> as a reliable source for current guidelines). More information can also be found at <http://www.whitehouse.gov/administration/eop/onap/nhas>.

Increasing Access to HIV Care and Treatment (IAHCT)

In observance of the 2011 World AIDS Day, President Obama announced the availability of \$50 million in additional funding to fight HIV/AIDS in the United States, including \$15 million for Ryan White HIV/AIDS Part C Early Intervention Services (EIS) Programs that provide HIV care

and treatment for People Living With HIV/AIDS (PLWHA) and \$35 million for AIDS Drug Assistance Programs.

In FY 2012, HRSA awarded the Increasing Access to HIV Care and Treatment (IAHCT) supplemental funds to current Ryan White HIV/AIDS Part C Early Intervention Services (EIS) grantees. IAHCT will increase access to HIV care and treatment by increasing support to existing grantees.

Part C EIS Program Requirements and Expectations

Required Services

The following primary care services must be provided to all persons living with HIV/AIDS, whether on-site or at another facility:

HIV counseling, testing, referral, and partner counseling services

HIV counseling, testing, referral, and partner counseling should be available for high risk targeted service populations, but Part C funding for these services should not duplicate services from other sources, if these are available and accessible to the targeted population(s). Instead, linkages and formal referral mechanisms should be established with these programs to ensure follow-up and evaluation for those persons identified as HIV-positive. Part C funding should not be used for routine HIV testing in general patient populations or generic efforts such as health fairs.

If HIV counseling, testing, referral, and partner counseling are provided directly by the applicant, these services must comply with provisions stipulated by the Department of Health and Human Services (DHHS) in accordance with Sections 2661, 2662 and 2663 of the Ryan White HIV/AIDS Program. The Revised Guidelines for Counseling, Testing, and Referral are available at: <http://aidsinfo.nih.gov/>. The counseling, testing and referral program also must assure the confidentiality of patient information in compliance with applicable Federal, State, and local law.

Medical evaluation and clinical care

Medical evaluation and clinical care includes CD4 cell monitoring, viral load testing, antiretroviral therapy, prophylaxis and treatment of opportunistic infections, malignancies and other related conditions, routine immunizations, prevention of perinatal transmission, and patient education, including linkage to prevention services.

Funded programs must offer individuals a comprehensive continuum of HIV care including primary medical care and, when applicable, perinatal care. At a minimum, the applicant, in accordance with the latest HHS guidelines, should provide periodic medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies and other AIDS defining conditions. The program also must provide for a system to confirm the presence of HIV infection, and must provide tests to diagnose the extent of deficiency in the immune system. Individuals must have access to ongoing prevention services while other treatment is being administered. The system of care must provide appropriate diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions, conforming to the most recent clinical care protocols. The program must also have a system in place for after-hours and weekend clinical coverage for medical and dental

services.

Tuberculosis, Hepatitis B and C, and sexually transmitted infections (STI) evaluation and treatment are indispensable components of an HIV primary care program. Ryan White Part C EIS programs should be able to diagnosis, prophylaxis, and treat or refer persons co-infected with these diseases. Program-wide clinical protocols should be in place to address these co-morbidities.

To ensure consistency and continuity of care, the clinical staff of the program should track and coordinate all inpatient care. Staff should develop plans for the resumption of the care of the patient in the program once they have been discharged from the hospital. Likewise, Part C EIS programs are required to have a systematic tracking mechanism in place to follow-up on referrals for patients in the Ryan White program. The system of tracking referrals must include documentation of the outcome of the referral in the medical record. Part C EIS programs are required to have a plan for referring patients to biomedical research facilities or community-based organizations that conduct HIV-related clinical trials. For information on these protocols, call the AIDS Clinical Trials Information Service at 1-800-HIV-0440 or visit the AIDSinfo website at <http://www.aidsinfo.nih.gov> .

In the face of rapidly changing clinical management of HIV disease, continuing education opportunities must be provided to EIS program staff to ensure they remain abreast of clinical advances. The program must document, implement, and practice recommendations as presented in the following HHS guidelines. Program specific clinical protocols must be updated accordingly as changes occur in the HHS guidelines. The following publications are available on-line at <http://www.aidsinfo.nih.gov/> or may be obtained by calling: 1-800-HIV-0440.

- Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents
- Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents
- Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection
- Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the U.S.

Patients should be involved and fully educated about their medical needs and treatment options within the standards of medical care. A document describing patient rights and responsibilities should be posted in a prominent place within the facility, and policies should be reviewed with each patient at intake. The policies and posted document should clearly describe the recourse a patient has if he/she is dissatisfied with the care provided.

Other primary care medical services

In addition to providing each patient with a thorough medical evaluation and related clinical care, the applicant should ensure, directly or via referral, access to oral health care, adherence counseling, outpatient mental health care, outpatient substance abuse treatment, nutritional services and specialty medical care, as described below. If a program is unable to provide any of these services on-site, it may establish and demonstrate formal arrangements, such as contracts or memoranda of understanding with appropriate providers. It is recommended that all practitioners for these services have experience working with the target population and with HIV.

- **Oral Health:** Grant funds may be used to support the provision of oral health services by general dental practitioners, dental specialists, dental hygienists, and other trained dental providers at on-site facilities. Funds may also be used to secure or subsidize such services obtained off-site by referral. Funding may also be available through Part A, Part B, and Part D-supported programs in the area. If a HRSA-supported HIV/AIDS Dental Reimbursement Program (DRP) or Dental Community-Based Partnership Program (DCBP) exists in the service area, programs should document efforts to collaborate with the DRP and/or DCBP. A list of HRSA supported HIV/AIDS Dental Reimbursement awards is available on-line at: <http://hab.hrsa.gov/abouthab/partfdental.html#2>.
- **Treatment Adherence:** Successful treatment adherence programs are most effective when they use a multi-disciplinary approach. A treatment adherence program might include readiness assessments, patient education, adherence monitoring and counseling.
- **Outpatient Mental Health:** Outpatient mental health services include screening, assessment, diagnosis, and treatment of common mental health illnesses. Optimal mental health treatment requires a multidisciplinary approach involving primary care and/or specialty physicians and mental health professionals who are trained, experienced, and/or certified in the field.
- **Substance Abuse Services:** Outpatient substance abuse services include screening, assessment, diagnosis, and treatment of substance abuse related illnesses. Optimal substance abuse treatment requires a multidisciplinary approach involving primary care and/or specialty physicians and substance abuse professionals who are trained, experienced, and/or certified in the field.
- **Nutritional Services:** Nutritional services include: screening, nutrition education and/or counseling, dietary/nutritional evaluation, and nutritional supplements, optimally provided by a licensed, registered dietitian or licensed, registered nutritionist. Nutritional services may be provided in individual and/or group setting.
- **Specialty Care:** Patients must have access to specialty and subspecialty care. Such services may include access to hematology/oncology, dermatology, ophthalmology, gynecology, gastroenterology, and pulmonary care.

Prevent new infections by working with persons diagnosed with HIV and their partners

Applicants are encouraged to incorporate the *“Recommendations for Incorporating HIV Prevention into Medical Care of Persons Living with HIV”* into their clinical program. These recommendations were developed jointly by the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA) (Morbidity and Mortality Weekly Report July 18, 2003, Volume 52, Number RR-12).

Recommendations for Incorporating HIV Prevention into Medical Care of Persons Living with HIV provide the guidance for making risk screening, STI screening, and prevention messages part of the routine medical care delivered to patients with HIV infection. Please see <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>. Health care providers are in a unique position to help persons living with HIV/AIDS stop the further transmission of

HIV. Members of the health care team, including physicians, nurses, and mid-level providers have a strong influence on patients' behavior, and therefore can positively impact health-related choices by delivering brief prevention messages and asking patients about risk behaviors, in ways that are culturally and linguistically appropriate during patient visits. Health care providers can help to reduce the number of new HIV infections and impact the HIV epidemic by:

- **Screening patients for behavioral risk** through interviews or questionnaires regarding sexual and needle-sharing behaviors and screening for STIs and pregnancy.
- **Offering behavioral interventions** to change knowledge, attitudes, and behaviors to reduce personal risk of transmitting or acquiring other STDs. These might include posters and brochures in waiting and exam rooms; verbal discussions with patients supplemented by written materials; condoms readily accessible in the clinic; and referral to other persons or organizations providing services such as substance abuse treatment.
- **Providing partner counseling and referral services (PCRS)**, including partner notification, as described above. Such services can help the sex and needle-sharing partners of HIV-infected patients learn their HIV status and take steps to avoid becoming infected (or, if infected, to avoid infecting others) and gain earlier access to medical evaluation, treatment, and other services.

Activities and behavioral interventions related to prevention for current patients and others must be properly documented in the medical record or in other standard clinic sources.

Copies of the recommendations can be ordered by calling the National Prevention Information Network (NPIN) at (800) 458-5231 or visiting the NPIN Website at <http://www.cdcpin.org>.

Support Services

When funds are not available from other sources, EIS programs may use Part C EIS funds to provide support services necessary for HIV infected persons to achieve optimal HIV medical outcomes. Other program services include:

- **Outreach** to: a) those who may be at high risk of contracting the disease and need referral for counseling and testing; b) identify persons living with HIV/AIDS in order to enroll them in care; and c) health care providers to make them aware of the availability and benefits of EIS services
- **Non-medical case management** for persons infected with HIV to access support services such as housing, food pantry, and transportation
- **Consumer transportation for medical care**
- **Translation**
- **General health education materials**
- **Respite Care**

Outreach and case management services may not be duplicative of other existing and accessible community resources. They must be coordinated with the outreach and case management activities funded under Part A, Part B, or Part D of the Ryan White HIV/AIDS Program, or any other funding source. Outreach must be consistent with HAB Policy Notice 12-01: Use of Ryan White HIV/AIDS Program Funds for Outreach Services, available on the web at <http://hab.hrsa.gov/manageyourgrant/pinspals/outreachpolicy2012.pdf>.

Referral System

Each Part C EIS program must have a system in place for referring both uninsured and insured patients to health and social services and for following up on those referrals. Part C funds may be used to create and implement a referral process, and for related evaluation, diagnostic, and treatment services. The referral system should include a mechanism for referral to specialty and subspecialty care as well as a tracking mechanism to ensure the outcome and documentation of the referral. **However, because the emphasis of Part C EIS funding is for primary HIV medical care, Part C EIS funds should not be used for to support specialty consultations and treatment at the expense of providing basic HIV primary care services.**

Coordination and Linkages to Other HIV Programs

Optimum patient care results when grantees are knowledgeable about and coordinate with all available and accessible community resources. These resources may include federally-funded and non-federally-funded programs such as homeless, housing, substance abuse treatment, mental health treatment and other supportive services. The application for Part C EIS funds must:

- **Be consistent with the Statewide Coordinated Statement of Need (SCSN).**
- **Agree to participate in the ongoing revisions of the SCSN.**

A copy of the SCSN can be obtained from your State's Ryan White HIV/AIDS Program Part B Director. In addition, the program is required to coordinate services with other providers of health care services funded by the Ryan White HIV/AIDS Program including Part A, Part B, Part C EIS, Part D, Special Projects of National Significance, AIDS Education and Training Centers, the Dental Reimbursement Program, and the Community Based Dental Partnership Program. If an applicant organization is located in an Eligible Metropolitan Area (EMA) or a Transitional Grant Area (TGA), members of the organization are encouraged to participate in the activities of the Ryan White HIV/AIDS Program Part A Planning Council. Applicants must demonstrate that they have coordinated with and not duplicated Part A services. Also, if a program is located in a State/territory that has created a Part B HIV Care Consortium, the program must make reasonable efforts to participate in that consortium. If the applicant program is located near existing Part C EIS funded programs, it is expected that the applicant does not duplicate services provided in the service area and target population. All Part C EIS programs are also expected to coordinate and collaborate with other Part C EIS programs in the area. Programs located in the service area of an existing Part D program are expected to collaborate and coordinate services for women, infants, children and youth. A listing of Ryan White HIV/AIDS Program grantee contact information can be found at <http://hab.hrsa.gov/gethelp/granteecontacts.html>

Grantees are expected to collaborate with ongoing HIV prevention activities and establish formal linkages for referral of HIV-positive individuals for care. Part C EIS programs are also expected to collaborate with Community Health Centers and other publicly funded primary care services, mental health and substance abuse treatment services including those funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), and research programs including those funded by the National Institutes of Health (NIH).

Program Evaluation

Programs are required to develop an evaluation strategy with outcome measures that

demonstrate achievement of the program's goals and objectives.

Programs are required to have an information system that has the capacity to manage and report the following administrative, fiscal, and clinical data:

- Service specific by patients
- Program income
- Track services according to funding source
- Demonstrate time and effort (general and acceptable accounting practices)
- The number of individuals provided early intervention services/primary medical care
- Demographic data on the patients receiving services.
- Epidemiological data on the population receiving services, including the extent of new TB infections, active TB cases, and multi-drug resistant tuberculosis (MDR-TB).
- Exposure and diagnostic categories on the population receiving services.
- The number of HIV infected individuals and the CDC classification of their disease.
- The extent to which the costs of HIV-related health care are paid by third party payers.
- The average costs of providing each category of early intervention service/primary care.
- The aggregate totals for each category of data.
- Consistent monitoring of the subcontracts of the program to determine if they are providing effective services and if time and effort can be supported by invoices submitted for reimbursement.

Routinely analyzing these data will assist each program in making programmatic or fiscal adjustments that will benefit the program and patients. In addition, this data can be utilized when writing the Progress Report of the annual non-competing grant application and when asked to submit the annual Ryan White HIV/AIDS Program Services Report (RSR) that is due each March.

Medicaid Participation

Each program must be a participating Medicaid-certified provider for all services that are covered under the State Medicaid plan and must have a provider number from the State. If a program subcontracts services with a public or private entity to provide Medicaid reimbursable services, that entity must also be a participating Medicaid-certified provider. Grantees and their contractors are expected to vigorously pursue Medicaid enrollment for individuals who are likely eligible for Medicaid coverage, seek payment from Medicaid when they provide a Medicaid covered service for Medicaid beneficiaries, and also back bill Medicaid for Ryan White Program-funded services provided for all Medicaid eligible patients. If the program or a subcontractor does not impose a charge or accept reimbursement for health services from any third party, HAB may grant a waiver of this requirement. *Third party sources include Medicaid, Children's Health Insurance Programs (CHIP), Medicare (including the Part D prescription benefit), and private insurance. **The Ryan White HIV/AIDS Program is the payer of last resort, and grantees must ensure that alternate sources of payment are pursued.*** The waiver request should be submitted with the application.

Patient Payment for Services

Applicants must develop consistent and equitable policies and procedures related to verification of patients' financial status, implementation of a sliding fee scale, and ensuring a cap on patient charges for HIV-related services. In order to comply with these requirements, the program may need to provide additional staff training, develop patient education materials, and/or place notices in patient waiting rooms and reception areas.

- **Sliding Fee Scale:** Patients cannot be denied primary care if they are not able to pay for services. Part C EIS programs must provide a system to discount patient payment for charges by developing and utilizing a sliding discounted fee schedule that is published and made readily available. While the fee schedule may be based on the patient's income or household size and income, the organization must track the patient's income and charges imposed. The law prohibits imposing a first-party charge on individuals whose income is at or below 100 percent of the Federal Poverty Level and requires that individuals with incomes above the official poverty level be charged for services. Each program is responsible for creating its own sliding fee scale in accordance with the most recent Federal Poverty Level guidelines. Federal Poverty Guidelines are updated each year in early spring, and are available on the web at <http://aspe.hhs.gov/poverty/index.shtml#latest>.

Patient Cap on Charges: The law limits the annual cumulative charges to an individual for HIV-related services to:

Individual Income	Maximum Charge
At or below 100% of Poverty	\$0
101% to 200% of Poverty	No more than 5% of gross annual income
201% to 300% of Poverty	No more than 7% of gross annual income
Over 300% of Poverty	No more than 10% of gross annual income

Each Part C EIS program must have a system in place to ensure that these annual caps on charges to patients are not exceeded.

Program Income: Programs are required to maximize the service reimbursement available from private insurance, Medicaid, Medicare, and other third-party sources. Programs are required to track and report all sources of service reimbursement as program income on the annual Federal Financial Report and in annual data reports. All program income earned must be used to further the objectives of the HIV program. The Ryan White HIV/AIDS Program is the payer of last resort, except for programs administered by or providing the services of the Indian Health Service. While program income must be maximized, Part C cannot be a supplement to third party payments. Please note that direct or indirect grant funds such as Ryan White HIV/AIDS Part A, Part B, Part D, and Part F programs are not program income and cannot duplicate services funded under Part C. Services provided under Part C cannot also be billed to Parts A, B, D, or F.

Limitation on Administrative Expenses: Not more than 10 percent of the approved Part C EIS Federal grant funds may be used for administrative costs, including planning and evaluation. Administrative expense caps do not include the costs of a clinical quality management program. Indirect costs will be allowed only if the applicant has a Federal negotiated indirect cost rate. All indirect costs are considered administrative and subject to the ten percent (10%) limitation.

Other Financial Issues: Programs must have appropriate financial systems in place that provide for internal controls, safeguarding assets, ensuring stewardship of Federal funds, maintaining adequate cash flow to meet daily operations, and maximizing revenue from non-Federal sources. Programs are required to monitor contractors under the grant to ensure that they are following the requirements of the program including the use of funds.

Because of the numerous financial requirements of the Ryan White HIV/AIDS Program Part C, grantees must seek approval to deviate from their approved budget if the changes are more than \$250,000 or twenty-five percent (25%) of the grant cumulatively during the year, or if the changes involve moving funds from one of the Part C Cost Categories to another. Such movement is considered to be a change of scope for the grant. Changing the model of care, e.g. nurse practitioners instead of physicians as the main providers of care, is also considered a change of scope. Approval for scope and budgetary changes must be authorized by the assigned Project Officer and processed through the electronic handbooks (EHB).

Patients who need medications and are eligible for State drug reimbursement programs funded under Part B of the Ryan White HIV/AIDS Program or other pharmaceutical programs should be assisted in accessing these resources prior to the use of Part C EIS grant funds for such purposes.

Additional Policies and Procedures for Program Operations

Consumer Involvement

It is a programmatic requirement that EIS programs will actively involve consumers in program development, implementation, and evaluation activities. “Consumers” are defined as persons living with HIV/AIDS (PLWHAs) or their representatives (i.e., those who represent PLWHAs who are unable to speak for themselves, such as HIV+ children and severely ill individuals) who are served by your program.

There are many ways to involve consumers, and each program should design consumer involvement that best suits its situation. To accomplish effective consumer involvement, programs should provide necessary training, mentoring, supervision, and reimbursement of expenses. Examples of consumer involvement are:

- HIV consumer representation on the organization’s Board of Directors.
- Establishment of an HIV specific Consumer Advisory Board.
- HIV consumer representation on an existing consumer advisory board.
- Involvement of HIV consumers on workgroups, committees and task forces, such as a Quality Committee, an Outreach Task Force, or a Patient Education Committee.
- Using HIV consumers as peer educators, outreach workers, or staff in the clinic, with fair and equitable pay for the job they are hired to perform.
- Involving HIV consumers through surveys, consumer forums, and focus groups.
- Using HIV peer trainers to work directly with patients to help them address issues related to making healthy decisions, gaining access to clinical trials, managed care, etc.

Drug Pricing Program

Programs funded under this grant are eligible for and should demonstrate participation in

HRSA's 340B Drug Pricing Program. This program enables Part C EIS grantees to purchase medications at a reduced rate. Detailed program information is available on-line at <http://www.hrsa.gov/opa/>.

For more information, contact:
Office of Pharmacy Affairs
5600 Fishers Lane,
Parklawn Building, mail stop 10C-03
Rockville, MD 20857
1-800-628-6297

2. Background

This program is authorized by Sections 2651 - 2667 and 2693 of the Public Health Service Act (42 USC 300ff -51-67, and 121), as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87).

HAB Guiding Principles

HAB has identified four factors that have significant implications for HIV/AIDS care services and treatment, which should be considered as the application and program are developed and refined:

- Revise care systems to meet emerging needs,
- Ensure access to quality HIV/AIDS care,
- Coordinate Ryan White HIV/AIDS Program services with other health care delivery systems, and
- Evaluate the impact of Ryan White HIV/AIDS Program funds and make needed improvements.

HRSA evaluates its programs through use of the Government Performance and Results Act (GPRA) Modernization Act of 2010, and actively uses the performance data to monitor achievements toward meeting HRSA's strategic goals. HAB has identified program/Part specific measures under GPRA and overarching performance measures are used to demonstrate progress in meeting the needs of uninsured or underinsured individuals. The overarching performance measures look at performance of Ryan White HIV/AIDS Program grantees across all programs/Parts.

GPRA measures specific to the Part C EIS program include:

Goal I: Improve Access to Quality Health Care and Services

Sub-Goal: Strengthen health systems to support the delivery of quality health services.

Long-Term Measure

By 2014, reduce deaths of persons due to HIV infection.

Annual Measure

Number of persons who learn their serostatus from Ryan White HIV/AIDS Programs.

Sub-Goal: Promote innovative and cost-efficient approaches to improve health

Long-Term Measure

By 2014, Ryan White HIV/AIDS Program-funded HIV primary medical care providers will have implemented a clinical quality management program and will meet two “core” standards included in the *Guidelines for Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*.

Annual Measure

Percentage of Ryan White HIV/AIDS Program-funded primary medical care providers that will have implemented a clinical quality management program.

Goal III: Building Healthy Communities

Sub-Goal: Lead and collaborate with others to help communities strengthen resources that improve health for the population

Annual Measure

Number of people receiving primary care services under Early Intervention Services Programs

Goal IV: Improve Health Equity

Sub-goal: Reduce disparities in quality of care across populations and communities.

Long-Term Measure

By 2014, increase the number of racial/ethnic minorities and the number of women served by Ryan White HIV/AIDS Program -funded programs.

Annual Measures

- 1) Proportion of racial/ethnic minorities in Ryan White HIV/AIDS Program-funded programs served.
- 2) Proportion of women in Ryan White HIV/AIDS Program-funded programs served.
- 3) Proportion of new Ryan White HIV/AIDS Program HIV-infected Patients who are tested for CD4 count and viral load.

Improving Quality

The proposed National Quality Strategy (NQS) will pursue three broad aims: 1) Better Care, 2) Healthy People/Healthy Communities, and 3) Affordable Care. In supporting actions to address the priorities, the intention of the National Strategy is “to create a new level of cooperation among all the stakeholders seeking to improve health and health care for all Americans.”

The Public Health Service Act requires recipients of funding under the Ryan White HIV/AIDS Part C program to establish clinical quality management programs to:

- Assess the extent to which HIV health services are consistent with the most recent HHS guidelines for the treatment of HIV disease and related opportunistic infections, and
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

HAB has defined quality as follows:

“Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluations of the quality of care should consider (1) the quality of inputs, (2) the quality of the service delivery process, and (3) the

quality of outcomes, in order to continuously improve systems of care for individuals and populations.”

Your Clinical Quality Management (CQM) program should ensure that systematic and continuous processes are in place for measuring performance and planning, implementing, and evaluating improvement strategies. If other organizations provide primary care for your organization via subcontract, you are responsible for assuring that CQM systems are in place at those organizations. Your subcontracts must include provisions regarding monitoring and CQM, and you may require regular data sharing and reporting from your subcontractors on this issue. It is a program expectation of the Ryan White HIV/AIDS Program, that grant funding spent on clinical quality management will be kept to a reasonable level.

The three-fold purpose of CQM is to ensure:

- Funded services adhere to established HIV clinical practice standards and HHS HIV treatment guidelines.
- Strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence with HIV medical care.
- Available demographic, clinical, and health care utilization information is used when developing and adapting programs to address changing trends in the epidemic.

All Part C EIS CQM programs must include quality goals and performance measures. HRSA/HAB encourages grantees to select measures that are most important to their agencies and the populations they serve. HRSA/HAB has developed HIV performance measures for use in monitoring the quality of care provided. Grantees are encouraged to identify performance measures that are responsive to their program, services provided, and local trends and to include these performance measures in their quality management plans. The HAB HIV performance measures can be found at <http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>.

In addition to performance measurement and quality improvement, your CQM program also must have:

- Designated leaders and accountability.
- Routine data collection and analyses of data on measurable outcomes.
- A system for ensuring that data are fed back into your organization’s quality improvement process to assure goals is accomplished.
- Consistency, to the extent possible, with other programmatic quality improvement activities, such as The Joint Commission (TJC), Center for Medicare and Medicaid Services (CMS) Physician Quality Reporting System and Meaningful Use, and other HRSA funded programs.

HAB also encourages grantees to conduct continuous quality improvement (CQI) for the administrative and fiscal components of their organization.

For all subcontractors and vendors a mechanism must be in place to ensure care and services meet HHS guidelines (available at <http://www.aidsinfo.nih.gov/>), standards of care or best practices, as applicable, based on services funded.

Applicants may wish to expand their knowledge of CQM programs. The following sites can provide entry points:

HRSA/HAB Quality Tools: <http://hab.hrsa.gov/deliverhivaidscares/qualitycare.html>

The National Quality Center: <http://www.nationalqualitycenter.org>

HIVQUAL-US Program: <http://hivqualus.org>

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding during Federal fiscal years 2013 - 2015. Approximately **\$6,009,353** is expected to be available annually to fund eleven (11) grantees. Applicants, including those for open service areas, may apply for a ceiling amount of up to the Fiscal Year 2012 funding level, including any Increasing Access to HIV Care and Treatment supplemental funds, as described in Appendix B. The project period is three (3) years. Funding beyond the first year is dependent on the availability of appropriated funds for the Ryan White HIV/AIDS Part C EIS Program in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government. Inadequate progress and/or justification may result in the reduction of approved funding levels.

III. Eligibility Information

1. Eligible Applicants

This competition is open to existing Part C EIS grantees **with project periods ending June 30, 2013**, to new organizations proposing to replace a current grantee, and to applicants for open service areas as described in **Appendix B**. New organizations who seek to replace current grantees must demonstrate that they will serve the existing patients, target populations, scope of services, and service areas currently served by the grantee they intend to replace. Applicants must identify the grantee they intend to replace. Eligible applicants include public entities and nonprofit private entities. Faith-based and community-based organizations, Tribes, and tribal organizations are also eligible to apply.

New applicants intending to replace a current grantee must be public entities and nonprofit private entities that are:

- a) Federally-qualified health centers under section 1905(1)(2)(B) of the Social Security Act;
- b) Grantees under section 1001 (regarding family planning) other than States;
- c) Comprehensive hemophilia diagnostic and treatment centers;
- d) Rural health clinics;
- e) Health facilities operated by or pursuant to a contract with the Indian Health Service;

- f) Community-based organizations, clinics, hospitals and other health facilities that provide early intervention services to those persons infected with HIV/AIDS through intravenous drug use; or
- g) Nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV/AIDS, including faith-based and community-based organizations.

All applicants, including current grantees, must document Medicaid provider status. Applicants may document formal agreements with Medicaid providers for provision of all services covered under the Medicaid State plan. This requirement may be waived for free clinics that do not impose a charge for health services and do not accept reimbursement from Medicaid, Medicare, or private insurance. All applicants, including current grantees, must document that they are fully licensed to provide clinical services, as required by their State and/or local jurisdiction. Medicaid provider status and licensure must be in place prior to submitting an application.

2. Cost Sharing/Matching

There is no required match or other cost participation requirement for this program.

3. Other

Applications that request more than the total Fiscal Year 2012 base award indicated in Appendix B will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

NOTE: Multiple applications from an organization are not allowed.

HAB Expectations Post Award

Clinical care, diagnostic services, periodic medical evaluations, and therapeutic measures to treat HIV/AIDS must be provided to patients within 90 days from award start date. The ability to provide primary medical care includes hiring clinical staff, providing HIV primary medical care, and having the capability to bill for services. When services are provided through contracts, grantees must be able to provide a copy of the contracts signed by both parties to HRSA within 60 days of the award. These contracted services must document the total number of HIV positive patients to be served by the Ryan White funded program. Providers must comply with Part C legislative and program requirements, including data sharing, submission of Ryan White unduplicated data reports, and participation in CQM activities.

Medicaid/Medicare Provider Status and Clinic Licensure

All applicants, including proposed subcontractors, should document Medicaid/Medicare provider status for all primary medical care providers and case management agencies. Applicants should also document for their primary medical care providers and case management agencies that they are fully licensed to provide clinical and case management services, as required by their State and/or local jurisdiction. If clinic licensure is not required in the applicant's jurisdiction, describe how that can be confirmed in State regulations or other information. This information is required each year and should be noted as **Attachment 1**.

Grant recipients must also ensure that Medicaid/Medicare billable services are billed to Medicaid/Medicare. Ryan White HIV/AIDS Program funds are expected to be used as the **payer of last resort**, for example after billing Medicaid, Medicare, Children's Health Insurance Program (CHIP), other public/private health insurance resources, and after billing patients for allowable costs using a sliding fee scale. **Ryan White HIV/AIDS Program funds cannot be used to supplement payments by Medicaid, Medicare, or other insurance programs.**

Maintenance of Effort

These grant funds shall not be used to take the place of current funding for activities described in the application. Grantees must agree to maintain non-Federal funding for HIV early intervention services at a level that is not less than expenditures for such activities during the fiscal year prior to receiving this grant. This means that grantees must spend at least as much of their own funds on early intervention services as they did last year.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information

HRSA *requires* applicants for this funding opportunity announcement to apply electronically through Grants.gov. The registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting an application. All applicants *must* submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from DGPWaivers@hrsa.gov, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. If requesting a waiver, include the following in the e-mail request: the HRSA announcement number for which the organization is seeking relief, the organization's DUNS number, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to the submission along with a copy of the "Rejected with Errors" notification as received from Grants.gov. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline. Suggestion: submit application to Grants.gov at least two days before the deadline to allow for any unforeseen circumstances.

IMPORTANT NOTICE: CCR moved to SAM **Effective July 30, 2012**

The Central Contractor Registration (CCR) transitioned to the System for Award Management (SAM) on July 30, 2012.

For any registrations in process during the transition period, the data that has been submitted to CCR will be migrated to SAM.

If a record was scheduled to expire between July 16, 2012 and October 15, 2012, CCR is extending the expiration date by 90 days. The registrant received an e-mail notification from CCR when the expiration date was extended. The registrant then will receive standard e-mail reminders to update their record based on the new expiration date. Those future e-mail notifications will come from SAM.

SAM will reduce the burden on those seeking to do business with the government. Vendors will be able to log into one system to manage their entity information in one record, with one expiration date, through one streamlined business process. Federal agencies will be able to look in one place for entity pre-award information. Everyone will have fewer passwords to remember and see the benefits of data reuse as information is entered into SAM once and reused throughout the system.

Active SAM registration is a pre-requisite to the successful submission of grant applications!

Items to consider are:

- When does the account expire?
- Does the organization need to complete the annual renewal of registration?
- Who is the eBiz POC? Is this person still with the organization?
- Does anything need to be updated?

To learn more about the switch from CCR to SAM, more information is available at <https://www.bpn.gov/ccr/NewsDetail.aspx?id=2012&type=N>. To learn more about SAM, please visit <https://www.sam.gov>.

Note: SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). Grants.gov will reject submissions from applicants with expired registrations. Do not wait until the last minute to register in SAM. According to the SAM Quick Guide for Grantees (https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf), an entity's registration will become active after 3-5 days. Therefore, ***check for active registration well before the application deadline.***

Applicants that fail to allow ample time to complete registration with SAM or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide*, available online at <http://www.hrsa.gov/grants/apply/userguide.pdf>. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at <http://www.grants.gov/assets/ApplicantUserGuide.pdf>. This Guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

- 1) Downloading from <http://www.grants.gov>, or
- 2) Contacting the HRSA Digital Services Operation (DSO) at:
HRSADSO@hrsa.gov

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted. Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the “Application Format Requirements” section below.

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **HRSA strongly urges applicants to print their application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the *Electronic Submission User Guide* referenced above.**

Applications must be complete, within the 80-page limit, within the 10 MB limit, and submitted prior to the deadline to be considered under this announcement.

Application Format

Applications for funding must consist of the following documents in the following order:

SF-424 Non-Construction – Table of Contents

- 🔔 It is mandatory to follow the instructions provided in this section to ensure that the application can be printed efficiently and consistently for review.
- 🔔 Failure to follow the instructions may make the application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
- 🔔 For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
- 🔔 For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Pages 1, 2 & 3 of the SF-424 face page.	Not counted in the page limit
Project Summary/Abstract	Attachment	Can be uploaded on page 2 of SF-424 - Box 15	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
Additional Congressional District	Attachment	Can be uploaded on page 3 of SF-424 - Box 16	As applicable to HRSA; Counted in the page limit.
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424A Budget Information - Non-Construction Programs	Form	Pages 1–2 to support structured budget for the request of Non-construction related funds.	Not counted in the page limit.
Budget Narrative Attachment Form	Form	Supports the upload of Project Narrative document.	Not counted in the page limit.
Budget Narrative	Attachment	Can be uploaded in Budget Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form.	Not counted in the page limit.
Additional Performance Site Location(s)	Attachment	Can be uploaded in the SF-424 Performance Site Location(s) form. Single document with	Counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
		all additional site location(s)	
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for specific sequence. Counted in the page limit.

- 🔔 To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- 🔔 Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- 🔔 Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- 🔔 Merge similar documents into a single document. Where several documents are expected in the attachment, ensure that a table of contents cover page is included specific to the attachment. The Table of Contents page will not be counted in the page limit.
- 🔔 Please use only the following characters when naming your attachments: A-Z, a-z, 0-9, underscore (_), hyphen (-), space, period, and limit the file name to 50 or fewer characters. Attachments that do not follow this rule may cause the entire application to be rejected or cause issues during processing.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Table of Provider Medicaid and Medicare numbers and clinic licensure status (Required)
Attachment 2	Program specific Line Item Budgets-separate budget for each year of proposed project period (Required)
Attachment 3	Negotiated Indirect Cost Rate Agreement (If Applicable). Not counted in the page limit.
Attachment 4	Staffing Plan (Required)
Attachment 5	Job Descriptions for vacant positions (If Applicable)
Attachment 6	Signed and Scanned Part C EIS Additional Agreements and Assurances (Required)
Attachment 7	Proof of non-profit status (Required). Not counted in the page limit.
Attachment 8	Justification for Funding Preference Request (If Applicable)
Attachment 9	Map of Service Area (Required)
Attachment 10	Letter(s) from Part A and/or Part B Grantee (If Applicable)
Attachment 11	List of Provider Organizations with MOA/MOU (If Applicable)
Attachment 12	Work Plan Summary, with measurable objectives for the first year of the proposed project period (Required)
Attachment 13	Summary Progress Report (Required for Competing Continuation)

Attachment Number	Attachment Description (Program Guidelines)
Attachment 14	Organizational Chart (Required)
Attachment 15	Optional Attachments, as necessary

Application Format

i. *Application Face Page*

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. Important note: enter the name of the **Project Director** in 8. f. “Name and contact information of person to be contacted on matters involving this application.” If, for any reason, the Project Director will be out of the office, please ensure the email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.918.

Item 2 Type of Application

Current grantees should check “Continuation.” New applicants for existing service areas should check “New.”

Item 4 Applicant Identifier

Enter Not Applicable.

Item 5a Federal Entity Identifier

Enter Not Applicable.

Item 5b Federal Award Identifier

If you are a current grantee, enter your most recent 10-digit grant number from item 4a of your most recent Notice of Award. If you are not the current grantee of record, please leave this item blank.

Item 8c DUNS Number

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at <http://fedgov.dnb.com/webform> or call 1-866-705-5711. Please include the DUNS number in item 8c on the application face page. Applications **will not** be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being “Rejected for Errors” by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any sub recipient of HRSA award funds) is required to register annually with the System for Award Management (SAM) in order to conduct electronic business with the Federal Government. SAM registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that the applicant organization SAM registration is active and the Marketing Partner ID Number (MPIN) is current. Information about registering with SAM can be found at <http://www.sam.gov>. Please see Section IV of this funding opportunity announcement for SAM registration requirements.

Item 14 Areas Affected by Project

In an attachment, enter all counties in the proposed service area. This information will be different than the place(s) of performance reported on the SF-424 Project/Performance Site Location(s) Form, which describes the actual clinic locations.

Item 15 Descriptive Title of Applicant's Project

Fill in the required title and attach the Project Abstract.

Item 17 Proposed Project

The start date should be July 1, 2013. The end date should be June 30, 2016.

Item 19 Some states require that you submit a copy of your Federal grant applications to a Single Point of Contact (SPOC) at the state government level. If your state participates in the SPOC review process, enter the date you sent the copy of your Ryan White HIV/AIDS Program grant application to the SPOC office. A list of states and territories that currently participate in the SPOC review process can be downloaded from the internet at: http://www.whitehouse.gov/omb/grants_spoc.

ii. Table of Contents

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Budget

Please complete Sections A, B, E, and F of the SF-424A Budget Information – Non-Construction Programs form included with the application kit for each year of the project period, and then provide a line item budget using Section B Object Class Categories of the SF-424A.

Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period. In Section A use rows 1 – 3 to provide the budget amounts for the three years of the project. Please enter the amounts in the “New or Revised Budget” column- not the “Estimated Unobligated Funds” column. In Section B Object Class Categories of the SF-424A, provide the object class category breakdown for the annual amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use columns (2) through (3) for subsequent budget years. Applicants must request the same amount for each year.

Program-specific line item budgets: In order to evaluate applicant adherence to Part C EIS legislative budget requirements, applicants must submit separate program-specific line item budgets for each year of the proposed project period. These budgets will be uploaded as an attachment to the application as **Attachment 2**. NOTE: It is recommended that the budgets be converted or scan into a PDF format for submission. Do not submit Excel spreadsheets. Personnel should be listed separately by position title and the name of the individual for each position title, or note if vacant. It is recommended that a line item budget be submitted in table format, listing the program category costs (Early Intervention Services or EIS, Core Medical Services, Support Services, Clinical Quality Management, and Administration Costs) across the top and object class categories (Personnel, Fringe Benefits, etc) in a column down the left hand side. Since EIS must be 50% of the award and is also part of Core Medical Services, the EIS costs must be repeated in the Core Medical Services

Column. The amount requested on the SF424A and the amount listed on the program specific line-item budget must match. The budget must relate to the activities proposed in the Project Narrative and the Work Plan. The budget requested for each year is not to exceed the total award for the service area from FY 2012 before any carry-over and/or offset adjustments. The Ryan White HIV/AIDS Program has established the following specific **legislative criteria** for the expenditure of funds for Part C.

At least 50 percent of the total funds awarded must be spent on Early Intervention Services, as fully described below. Early Intervention Services as described in the legislation are laboratory testing, clinical and diagnostic services, periodic medical evaluations, therapeutic measures, and referrals for health and support services.

- After reserving funds for administration and clinical quality management, **at least 75 percent** of the remaining funds must be spent on Core Medical Services, which includes the Early Intervention Services (EIS).
- No more than 10 percent of the approved Part C EIS Federal grant funds awarded may be spent on administrative costs, including indirect costs, planning and evaluation, and excluding costs of a clinical quality management program.

The Ryan White HIV/AIDS Program also has established the program expectation that clinical quality management must be kept to a reasonable level, as described below. The remainder of the funds may be spent on support services, defined as those services needed for individuals living with HIV/AIDS to achieve their medical outcomes.

Core Medical Services are defined as:

- A. Outpatient and ambulatory health services
- B. AIDS Drug Assistance Program treatments (ADAP) under Part B
- C. AIDS pharmaceutical assistance
- D. Oral Health Care
- E. Early intervention services
- F. Health insurance premium and cost sharing assistance for low-income individuals in accordance with Part B
- G. Home health care
- H. Medical nutrition therapy
- I. Hospice Services
- J. Home and community-based health services as defined under Part B
- K. Mental Health Services
- L. Substance abuse outpatient care
- M. Medical case management, including treatment adherence services (NOTE: this is no longer an EIS cost)

Applicants may apply for a waiver of the Core Medical Services requirement in accordance with final notice published by HRSA in the Federal Register Notice, Vol. 73, No. 113, dated June 11, 2008, <http://edocket.access.gpo.gov/2008/pdf/E8-13102.pdf>. The OMB number for a Core Medical Services waiver request is 0915-0307. An extension of this requirement has been requested. To be considered for a 1-year waiver from the 75 percent core medical services expenditure requirement, applicants must submit:

- Certification from the Part B State Grantee that there are no ADAP waiting lists in the State. This certification also must specify that there are no waiting lists for a

particular core class of antiretroviral therapeutics established by the Secretary, e.g., Enfuvirtide (Fuzeon); and

- Certification that all Core Medical Services funded under the applicant's Ryan White HIV/AIDS Program grant are available to all eligible individuals in the area.

Requests for waivers should be submitted with the application. HRSA will respond in writing to core medical services waiver requests when the notice of award is issued.

Allowable Costs

The Part C EIS Program divides the allowable costs among five Part C Cost Categories. These

categories are **Early Intervention Services Costs, Core Medical Services Costs, Support Services Costs, Clinical Quality Management Costs, and Administrative Costs**. The Early Intervention Services Costs are repeated in the Core Medical Services Costs column because all Early Intervention Services are part of the Core Medical Services. The Total Column should include only Core Medical Services, Support Services, Clinical Quality Management, and Administration.

Early Intervention Services Costs are those costs associated with the direct provision of medical care. In accordance with current legislation, Early Intervention Services costs must be at least 50 percent of the entire Federal Part C EIS budget. A Part C program must expend grant funds to provide HIV primary care in the proposed service area. These services must be reflected in the budget. Staff positions such as medical assistants, dental hygienists, and nurses can be included in the budget when the position proportionately complements HIV primary medical care providers such as physicians, dentists, physician assistants, or nurse practitioners being funded by the Part C program. Part C Early Intervention Services costs include:

- Salaried personnel, contracted personnel or visit fees which provide primary medical care, laboratory testing, oral health care, outpatient mental health and substance abuse treatment, specialty and subspecialty care. Provider time must be reasonable for the number of patients.
- Personnel (salaried or contracted), or fee for service, who provide or refer for health services such as treatment adherence monitoring/education services when provided by licensed providers.
- Lab, x-ray, and other diagnostic tests
- Medical/dental equipment and supplies
- Transportation for clinical care provider staff to provide care at satellite clinics
- Other clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV/AIDS according to the DHHS guidelines. <http://www.aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0/>

Core Medical Services Costs include those listed above **plus** the following:

- HIV Post-Test Counseling and test kits (this should not duplicate HIV testing and counseling services from other sources)
- Medical Case Management staff who provide a range of patient-centered services that result in a coordinated care plan, which links patients to medical care, psychosocial, and other services including treatment adherence services.

The following Core Medical Services have historically been paid by Parts A or B but not Part C, and should only be provided by Part C with justification:

- AIDS Drug Assistance Program treatments
- Health Insurance Premium and cost sharing assistance for low income individuals
- Home health care
- Hospice Services
- Home and community-based health services as defined under Part B

Clinical Quality Management Costs are those costs required to maintain a clinical quality management program to assess the extent to which services are consistent with the current HHS guidelines for the treatment of HIV/AIDS. It is a program expectation that grant funding spent on clinical quality management will be kept to a reasonable level. Travel should be limited to required HRSA meetings and necessary continuing education for providers funded under the grant. Excessive conference travel will not be approved. Funding of quality management/data collection staff should be in proportion to the number of patients served under the grant. Examples of clinical quality management costs include:

- Clinical Quality Management coordination
- Continuous Quality Improvement (CQI) activities
- Data collection for clinical quality management purposes (collect, aggregate, analyze, and report on measurement data)
- Consumer involvement to improve services
- Staff training/technical assistance (including travel and registration) to improve services- this includes the annual clinical update and the biennial Ryan White All Grantees Meeting
- Participation in Statewide Coordinated Statement of Need process and local planning
- Electronic Health Records: Data analysis for CQM purposes

Support Services Costs are those costs for services which are needed for individuals living with HIV/AIDS to achieve optimal HIV medical outcomes. Support Service Costs include:

- Patient transportation to medical appointments
- Intake/eligibility specialists
- Translation services, including interpretation services for deaf persons
- Patient Education materials
- Non-medical Case Managers
- Non-licensed/credentialed staff providing treatment adherence counseling
- Outreach staff (case finders) to identify people with HIV, or at-risk of contracting HIV, to educate them about the benefits of early intervention and link them into primary care not supported by other funding sources
- Health Educators
- Peer to peer education/support
- Patient Navigators/Community Health Worker
- Local travel by staff to provide support services
- Respite Care (can be provided by Part C with justification)

Administrative Costs are those costs associated with the administration of the Part C EIS grant. By law, no more than ten percent (10%) of the Part C EIS budget can be spent on

administrative costs. The costs of a clinical quality management program are not considered an administrative expense. Staff activities that are administrative in nature should be allocated to administrative costs. Examples of administrative costs include:

- Indirect Costs, which are allowed only if the applicant has a negotiated indirect cost rate approved by a recognized Federal agency. A copy of the latest negotiated cost agreement that covers the period for which funds are requested must be submitted as Attachment 3 of the application. Indirect costs are those costs incurred by the organization that are not readily identifiable with a particular project or program, but are considered necessary to the operation of the organization and performance of its programs. All indirect costs are considered administrative for the Part C EIS program and, therefore, are subject to the 10 percent limitation on administrative expense
- Rent, utilities, and other facility support costs related to management of grant funds
- Personnel costs and fringe benefits of staff members responsible for the management of the project (such as the Project Director and program coordinator), non-CQM program evaluation, non-CQM data collection/reporting, supervision, and other administrative, fiscal, or clerical duties
- Telecommunications, including telephone, fax, pager and internet access
- Postage
- Liability insurance
- Office supplies
- Audits
- Payroll/Accounting services
- Computer hardware/software not directly related to patient care
- Program evaluation, including data collection for evaluation
- Receptionist
- File clerk
- Medical billing staff
- Electronic Health Records: Maintenance, Licensure, Annual Updates, Data Entry

Salary Limitation:

The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual’s base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts under a HRSA grant or cooperative agreement.

As an example of the application of this limitation: If an individual’s base salary is \$350,000 per year plus fringe benefits of 25% (\$87,500) and that individual is devoting 50% of their time to this award, their base salary should be adjusted to \$179,700 plus fringe of 25% and a total of \$112,312.50 may be included in the project budget and charged to the award in salary/fringe benefits for that individual. See the breakdown below:

Individual’s <i>actual</i> base full time salary: \$350,000	
50% of time will be devoted to project	
Direct salary	\$175,000
Fringe (25% of salary)	\$43,750

Total	\$218,750
Amount that may be claimed on the application budget due to the legislative salary limitation:	
Individual's base full time salary <i>adjusted</i> to Executive Level II: \$179,700 50% of time will be devoted to the project	
Direct salary	\$89,850
Fringe (25% of salary)	\$22,462.50
Total amount	\$112,312.50

iv. Budget Justification

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period at the time of application. Line item information must be provided to explain the costs entered in the SF-424A. Be very careful about showing how each item in the “other” category is justified. For subsequent budget years, the justification narrative should highlight the changes from Year One or clearly indicate that there are no substantive budget changes during the project period. The budget justification **MUST** be concise. Do **NOT** use the budget justification to expand the project narrative.

Explain how you estimate or calculate each proposed line-item amount by providing a calculation that contains the estimated cost per unit, the estimated number of units, and the number of persons to receive the service. For example, if the budget includes a \$12,000 line-item for lab tests, the expenses must be justified with an explanation in the *Budget Justification* section as follows: “10 viral load tests at \$100.00 each per month x 12 months for 60 patients= \$12,000.”

Under each class category, e.g., *Personnel* as listed below, the budget justification must be divided according to the Part C EIS cost categories, EIS, other Core Medical Services, Support Services, Clinical Quality Management, and Administration. The description must be specific to the cost category. A general description which is repeated across categories is not acceptable.

Budget for Multi-Year Award

This announcement is inviting applications for project periods up to three (3) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be up to three (3) years. Submission and HRSA approval of the Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the three-year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. **Duties described must be specific to each cost category.**
Reminder: Award funds may not be used to pay the salary of an individual at a rate in

excess of Executive Level II or \$179,700. An individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements. Please provide an individual's actual base salary if it exceeds the cap. See the sample below.

Sample:

Name	Position Title	% of FTE	Annual Salary	Amount Requested
J. Smith	Chief Executive Officer	50	\$179,700*	\$89,850
R. Doe	Nurse Practitioner	100	\$75,950	\$75,950
D. Jones	Data/AP Specialist	25	\$33,000	\$8,250

*Actual annual salary = \$350,000

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project. (If an individual's base salary exceeds the legislative salary cap, please adjust fringe accordingly.)

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. Clinical staff traveling to provide care is included in EIS, while patient transportation is included in Support Services. All other travel to workshops or conferences is included in CQM.

Grantees are expected to include in their budgets travel expenses for up to two persons to attend the Ryan White HIV/AIDS Program All-Grantees Meeting (held every other year) and one clinician to attend the Annual HIV Clinical Update Meeting. In the year that the All-Grantees Meeting is not held, another continuing education clinical conference may be substituted.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

Contractual: Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential sub-recipients that entities receiving sub-awards must be registered in SAM and provide the recipient with their DUNS number.

Contractors providing services under this grant must adhere to the same requirements as the grantee. All legislative and program requirements that apply to grantees also apply to sub-recipients of their awards. The grantee is accountable for the sub-recipient's performance of the project, program, or activity, the appropriate expenditure of funds under the award; and the other obligations of the Part C award. **Grantees are required to annually monitor all subcontractors.** Assurance that subcontractors are computing and reporting program income is a Ryan White HIV/AIDS Program Requirement. Subcontractors must also report and validate program expenditures in accordance with budget categories to determine legislative mandates are met.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

Indirect Costs: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them. The indirect cost rate agreement will not count toward the page limit.

v. Staffing Plan and Personnel Requirements

Applicants must present a staffing plan and provide a justification for the plan that includes duties, education and experience qualifications and rationale for the amount of time being requested for each staff position in **Attachment 4**. The staffing plan should include elements of the biographical sketches and job descriptions, including education, training, HIV experience and expertise, language fluency, and experience working with the cultural and linguistically diverse populations that are served by their programs. Separate biographical sketches will not be required. The staffing plan should include all positions funded by the grant, as well as staff vital to program operations and the provision of HIV services whether or not paid by the grant. Key staff include, at a minimum, the program

coordinator and the program medical director, and all medical care providers funded directly or through a contract. The program coordinator is responsible for the oversight and day to day management of the proposed Part C EIS Program, and the medical director assumes responsibility for all clinical aspects of the grant. Specifically identify the person in the staffing plan who will lead the quality management activities, both clinical and non-clinical, for this grant. This person may or may not be supported by the grant funds. Specifically, identify staff that manage the grant and monitor contractors' use of funds, provision of services, quality and data submission, whether or not they are paid under this grant. For each staff, note all sources of funding and the corresponding time effort. Applicants are encouraged to supply this information in a table. Job descriptions that include the roles, responsibilities, and qualifications of proposed project staff not yet hired must be included in **Attachment 5**.

vi. Assurances

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package. Review the *Part C Additional Agreements and Assurances* in **Appendix A**. The document must be signed by the Authorized Organizational Representative (AOR), scanned, and attached to the application as **Attachment 6**. **For new applicants**, provide proof of the organization's non-profit status (such as 501(c) (3)) Status as determined by the Internal Revenue Service as **Attachment 7**.

vii. Certifications

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package.

viii. Project Abstract

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served.

Please place the following at the top of the abstract:

- Project Title
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

The project abstract must be single-spaced and limited to two pages in length.

The Project Abstract must have the following five subheadings:

- 1) Summary of Request:** A short statement briefly describing the funding requested, the requested services, specific sites where they will be provided, and the amount of funding requested. If this is a **new application**, identify the grantee listed in **Appendix B** that this application is intend to replace. Indicate whether you are requesting funding preference as described in the Review and Selection Process Section of this funding

opportunity announcement. Funding preference must be explicitly requested, and must be specifically justified.

- 2) **Target Population(s):** A brief description of the geographic area (including counties) to be served by the proposed project, including socio-economic and demographic characteristics of the target population(s) affected by HIV in that specific area.
- 3) **Current HIV Service Activities:** A description of the HIV services currently available in the service area. Also list those HIV services that are provided specifically by your organization. Include the number of patients who received primary medical care from your program in **each of the last three calendar years.**
- 4) **Problem:** A summary of the principal problems and unmet needs of people living with HIV in the applicant's service area that will be addressed if the proposed project is funded.
- 5) **Objectives:** List the major objectives for the project period as described in the Work Plan Summary.

ix. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed project. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Use the following section headers for the Narrative:

▪ **INTRODUCTION**

This section should briefly describe the problem and the associated factors contributing to it. You may wish to expand on information presented in the "Problem" section of the abstract. If you are a new applicant, identify the grantee listed in **Appendix B** that you intend to replace. Indicate whether you are requesting funding preference as described in the Review and Selection Process Section of this funding opportunity announcement. Funding preference must be explicitly requested, and must be specifically justified as described in **Attachment 8.**

▪ **NEEDS ASSESSMENT**

This section is scored under Review Criterion 1: Need. This section outlines the needs of the community. If your organization cannot demonstrate the need for this funding, the application will be not considered. The four (4) required components of the needs section are:

- 1) HIV Seroprevalence and Surrogate Markers
- 2) The Social Context of HIV/AIDS
- 3) Target Populations
- 4) The Local HIV Service Delivery System and describe current changes in that system

1) HIV Seroprevalence and Surrogate Markers: The Ryan White HIV/AIDS Program gives preference to applicants who make services available in geographic areas that have experienced an increase in the burden of HIV disease and in the burden as a care provider organization for people living with HIV. The increased burden must be demonstrated over the past two years. Use this section to provide and discuss data on the incidence and

prevalence of HIV and AIDS in the proposed service area. Include information on AIDS incidence, AIDS prevalence, HIV incidence, HIV prevalence, and unmet need from the State's grantee of record for Part B <http://hab.hrsa.gov/abouthab/partbstates.html>, and from the Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA) grantee of record for Part A <http://hab.hrsa.gov/abouthab/parta.html> if applicable. Remember to cite the source(s) of the data that is presented.

This section should include a table which clearly shows burden of care in the proposed service area. For **each** of the years, **2009, 2010, and 2011**, show the following information. (If data for this time period is not available, please explain why.)

- The number of people newly reported with HIV-non-AIDS (incidence)
- The number living with HIV-non-AIDS (prevalence)
- The number newly reported with AIDS
- The number living with AIDS
- The number testing positive and overall seroprevalence for HIV testing
- You may also include the rates of diseases such as syphilis, gonorrhea, tuberculosis, Hepatitis C, and substance abuse that indicate a prevalence of high risk behaviors associated with HIV transmission.

In a narrative, discuss the epidemic in the proposed service area as compared to State or to EMA data. Discuss whether Part A or B estimates of unmet need, which includes people who know they are HIV positive but are not in care, apply to the proposed service area. Discuss the similarities, differences, and trends noted in such areas as race, ethnicity, gender, and exposure category. Highlight any new groups that show a rapid growth in HIV or AIDS cases and provide an estimated rate of increase or decrease in the number of reported HIV or AIDS cases for the given period. In this section, give both baseline numbers and percent change. (e.g., this XYZ population grew 50 percent, from 100 to 150 people in year 2011).

This section may list other measures that show the impact of HIV on your community. Use data from a reliable source in this section of the application and clearly identify the source(s) for that data (e.g., the State Department of Health or the Centers for Disease Control and Prevention).

2) The Social Context of HIV/AIDS: Describe and discuss the social and economic characteristics of the community that the grant application proposes to serve. Discuss the community infrastructure for primary health care services in general; including the number and accessibility of the local community health centers and other publicly funded entities. Focus the discussion on how these conditions have an impact on the provision of HIV services in the proposed geographical area. If reliable information is available, an applicant may compare characteristics of the general population with the characteristics of HIV infected persons in the community. Examples of questions that may be addressed in this section include:

- What percentage of the population is African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders?
- What percentage of the population is homeless?
- What percentage of the population use drugs?

- What percentage of the population is unemployed?
- What percentage of the population is adolescent (ages 13-24)?
- What percentage of the population is uninsured?
- What percentage of the population lives below 100 % of the Federal Poverty Level?

The statistics included must be specific to the area from which the majority of the proposed patients will be drawn. Statistics from the State or larger area within the State may be cited for purposes of comparison or contrast. It may also be beneficial to include a description of other relevant characteristics of the target populations that affect their access to primary care. These factors may include primary language, citizenship status, education (e.g., high school graduation rate for the area), and access to transportation.

3) Target Populations: Information in this section may most easily be provided in a table. The applicant needs to clearly identify the populations that the organization will serve. It is important to compare the populations are proposed to be served to the general population of the area. It is recommended that the applicant specifically address the services targeted to the communities of color. **As stated in the National HIV/AIDS Strategy (NHAS), demonstrate how this addresses the NHAS goal: to reduce HIV-related health disparities.** To the extent possible, information on the target population(s) should include the distribution by race/ethnicity, gender, age, and mode of HIV transmission for both your current organization and for the proposed service area. Identify trends that have occurred over the last three years that the organization has confronted, such as increases or decreases among specific groups (e.g., a 10 percent increase from 200 to 220 in the number of African-American men who have sex with men seeking services). It is helpful to include statistics on persons most affected by the epidemic in the area, such as persons of color, women, and adolescents, as well as characteristics such as the general and adolescent pregnancy rate. Applicants are encouraged to clearly address the insurance status of the target population and provide data on number with third party resources (Medicaid or Medicare) as well as other Federal funds for care such as Part A and/or B. It is important to specifically include the number of patients with no health care resources, i.e. uninsured for the program and the proposed service area. Please site the date and source for the data that is provided.

4) The Local HIV Service Delivery System and recent changes: In this section the applicant must show what HIV primary care services are currently available in the service area. Refer to a map of the service area that shows the locations of local providers of HIV primary health care in the area, and include this map as **Attachment 9** of the application.

The presentation of the local HIV service delivery system should cover four broad areas: This information may be provided in a table.

- HIV service providers in proposed target area, including the applicant organization: List the public and private organizations that provide HIV services in the target area, the specific services each one provides, and, if possible, the number of unduplicated clients/patients each one serves annually. Part A and Part B information may be available in the HRSA Geospatial data warehouse, <http://datawarehouse.hrsa.gov/>, and the HAB Web site at <http://hab.hrsa.gov/>.
- Public funding in support of HIV services in the target area: Identify all Federal, State, and local funding sources for HIV prevention and care in the proposed

service area. Include providers funded by the CDC, NIH, and SAMHSA. Additional information may be available through the HHS web site Tracking Accountability in Government Grants System, <http://taggs.hhs.gov/>.

- Gaps in local services and barriers to care: Describe current unmet health needs and gaps in HIV primary medical care services for the targeted populations within the proposed service area. Discuss the populations which are not currently being served and/or define what services are not available. Provide a brief description of the impact the gaps in services have on your clients. Describe the barriers that prevent them from receiving the services they need. Applicants should address how they plan to overcome gaps in services, for example cultural/linguistic or gender gaps. Discuss the number and characteristics of persons who know they are HIV-infected but who are not receiving HIV primary medical care, as calculated by Part A and/or B in your area.
- Describe changes in the health care delivery system that affect the delivery of HIV primary care services in the target area and describe how the applicant organization has met with the challenges of these changes, e.g., managed care, Medicaid, Medicare, availability of ADAP funding, level or declining State and local funding.

▪ **METHODOLOGY**

Sections 1-6 and the Work Plan are scored under Review Criterion 2: Response. Section 7 is scored under Review Criterion 4: Impact. Use this section to describe your organization's scope of work for each of the services as described. The minimal information you should provide in each of these sections is described below. Refer to the description of Program Requirements and Expectations included in Section I. Services must be consistent with Policy Notice 10-02 which is available at:

(<http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html>). You may provide additional information that will help reviewers to understand how your services are delivered and the policies and procedures that ensure that your program maintains professional standards of care. It is recommended that this section contain an outline of how your organization will address the unmet needs and gaps in services outline in the Needs Assessment section above. For example, if a service area is lacking access to oral health care, the application should address this unmet need.

1) HIV Counseling, Testing, Referral, Partner Counseling, and Linking to Care

- Describe how counseling, testing and referral services to be funded under this award will specifically target high risk individuals. Describe the steps taken to ensure the confidentiality or the anonymity of patients and test results in accordance with State guidelines. As stated in the National HIV/AIDS Strategy (NHAS), demonstrate how this addresses the NHAS goal: to reduce the number of people who become infected with HIV.
- Describe special efforts over the most recent project period to increase enrollment in your services by persons most affected by the epidemic such as persons/communities of color, women, and adolescents. For new applicants, describe your efforts over the past three years. As stated in the National HIV/AIDS Strategy (NHAS), demonstrate how this addresses the NHAS goals: to increase access to care and optimize health outcomes for people living with HIV and to reduce HIV-related health disparities.
- Describe how patients who test HIV-positive receive facilitated and timely referrals to HIV primary care and other medical and health related services.
- Describe how individuals who know they are positive but are not receiving primary HIV medical care will be identified and enrolled in care.

- Describe policies and procedures for partner counseling services.
- Describe screening, education, and linking to care for Hepatitis B and C.
- Describe the organization's ability to facilitate the transfer of HIV-positive youth into adult care. Also describe the coordination of care to pediatric HIV care providers if this is not a service that you provide on-site. Describe how HIV positive youth (ages 13-24) are engaged in care and how the organization succeeds in keeping them in care.

2) Medical Evaluation and Clinical Care

- Describe the proposed diagnostic and therapeutic services that will be funded under this award for preventing and treating the deterioration of the immune system and related conditions. Include a description of clinical protocols to provide care to new patients and to ongoing patients. Include periodic medical evaluations, appropriate treatment of HIV infection, and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies, and other AIDS defining conditions. As stated in the National HIV/AIDS Strategy (NHAS), demonstrate how this addresses the NHAS goal: to increase access to care and optimize health outcomes for people living with HIV.
- Describe the on-site or contractual laboratory services that are available to the enrolled patients. Labs services include CD4, viral load, and genotype testing as well as routine health maintenance labs such as comprehensive metabolic panels and lipid profiles. Discuss the availability of State laboratory reimbursement (Part B) programs, if available.
- Discuss the availability of your State(s) AIDS Drug Assistance Program or other locally available pharmacy assistance programs and the methods in which patients gain access to medications in a timely manner or if there is a delay in receiving HIV related medications, what is the reason for the delay.
- Describe plans for staff training related to HIV primary care. Describe training available through your area's AIDS Education and Training Centers (AETC) and the training received by your staff.
- Describe how consumers are or will be involved in decisions regarding their personal health care regimens.
- Describe the policy/procedure for after-hours and weekend coverage for urgent or emergency medical and dental care needs.
- If you are a new organization applying to replace an existing grantee, describe in detail how your organization will improve services to the existing patients, population and service area of the existing grantee. In addition, describe how you will transition services from the existing grantee to your organization. Describe the activities, time frames, and efforts to coordinate the transition of services in a way that does not disrupt or impede the delivery of Part C EIS services to the existing patient population.

3) Referral System

- Describe how referrals to specialty and subspecialty medical care and other health and social services will be provided, for all patients, insured and uninsured.
- Describe how referrals are tracked and the results entered into the health record, including whether or not the appointment was kept and the results.
- Describe how coordination with admission/emergency room staff and discharge planners will occur during inpatient hospital visits.

- Describe how patients learn about HIV-related clinical research trials and the referral mechanisms to centers conducting clinical research trials.

4) Other Medical Services

- Describe how these services will be provided. If not funded under the grant, note the funding sources.
- Describe how oral health care (diagnostic, preventive, and therapeutic services) will be provided to patients with HIV infection.
- Describe how treatment adherence education will be provided by a licensed clinician.
- Describe how outpatient mental health treatment services will be provided.
- Describe how substance abuse treatment services will be provided.
- Describe how nutritional services will be provided.
- Describe how HIV prevention messages are incorporated into medical care for persons living with HIV, including screening patients for behavioral risk, offering behavioral interventions, and providing partner counseling and referral services. As stated in the National HIV/AIDS Strategy (NHAS), demonstrate how this addresses the NHAS goal: to reduce the number of people who become infected with HIV.
- Describe any other Core Medical Services as listed in the budget section that are being provided. Include medical case management if provided under the grant.

5) Support Services

- Describe targeted outreach efforts for specific communities of color served or that is proposed to be served by the organization.
- Describe how patients will have access to support services to achieve their HIV medical outcomes, including non-medical case management, translation, transportation, and any other services provided in the budget.

6) MAI

If the applicant is an existing grantee, note how much MAI funding the program received on the second page of the FY 2012 NOA, listed under grant-specific program terms. If the applicant currently does not receive MAI funding, this section does not apply.

If the award for FY 2012 lists MAI funds, the current application must include a description of the MAI population(s) served by the program (African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and/or Pacific Islanders). For each target population, describe briefly these items:

- The specific ethnic or minority group(s) served by the program.
- Outreach efforts of the program to recruit infected members of that group.
- How patients are identified who are members of that group.
- How patients are enrolled in care after they have identified them as HIV infected.
- How patients of this group are retained in care after they are enrolled.

Also, provide the following CY 2011 data for each ethnic or minority group (a table format is encouraged):

- Number enrolled in care at the beginning of 2011.

- Number newly identified during calendar year 2011.
- Number newly enrolled during calendar year 2011.
- Number lost to care during 2011, i.e. no medical visits in the past 12 months.
- Number enrolled at the end of 2011.

MAI data reporting should reflect any attrition in the program over time. Please do not use this section for any additional demographic information about the communities the program serves. Provide that in the Needs Assessment section.

7) Coordination and Linkages with Other HIV Programs

This section is scored in Review Criterion 4: Impact. Describe the organization's participation, coordination and/or linkage(s) with other publicly funded HIV care and prevention programs in the proposed service area. Address the following:

Part A: If the program is in a Part A EMA or TGA, describe the level of Part A funds utilized in the community for Core Medical Services and Support Services that are proposed in this application. Identify how the expected expenditures of the Part C grant have been developed in coordination with the planning process for localities funded under Part A. If the organization receives Part A funding:

- Identify the amount of funding received for each Part A service category, including the specific services supported and whether the funding supports FTE salaries or visits under a fee-for-service arrangement. If Part A funding is fee-for-service, describe how Part A funding does not duplicate services by providers funded under Part C.
- Describe how the services proposed in this application are consistent with, but not duplicative of services supported by Part A.
- Include in Attachment 10 of the application a letter from the Part A Grantee of Record that documents the applicant organization's involvement with Part A and in the Ryan White HIV/AIDS Program HIV Planning Council, if applicable. The letter must also address why Part C EIS funds are necessary to address the needs described in this application. If a letter is not obtainable, please explain why. Information about Part A is found at <http://hab.hrsa.gov/abouthab/parta.html>.

Part B: Identify how the expected expenditures of the Part C grant have been developed in coordination with the planning process for States funded under Part B.

- Identify the amount of funding received for each Part B service category, including the specific services supported and whether the funding supports FTE salaries or visits under a fee-for-service arrangement. If Part B funding is fee-for-service, describe how Part B funding does not duplicate services by providers funded under Part C.
- Describe how the services proposed in this application are consistent with, but not duplicative of services supported by Part B.
- Describe if the proposed Part C service area is located in a state/territory that has created a Part B HIV Care Consortium.
- Include in Attachment 10 a letter from the Part B Grantee of Record documenting
- The applicant organization's involvement in Part B activities. This letter must also

explain why Part C EIS funds are needed to address the needs described in this application. If a letter is not obtainable, please explain why. Information about Part B is found at <http://hab.hrsa.gov/abouthab/partbstates.html>

Part C EIS: If the applicant organization is located near other Part C EIS funded programs, explain how this proposal does not duplicate services provided in the proposed service area and for the target populations. If there are other Part C EIS supported programs in the area, identify those organizations, and describe the mechanisms in place for collaborating with them, sharing resources, and ensuring against duplication of services.

Other Ryan White HIV/AIDS Program funded providers in your area: Describe the applicant organization's participation, coordination and/or linkage with Part D; Part F Dental Reimbursement Program, Community Based Dental Partnership, or Special Projects of National Significance, if any exist in your area; and the nearest AIDS Education and Training Center.

HIV prevention activities in your area: Describe the organization's collaboration with ongoing HIV prevention activities in the area and how HIV-positive individuals are referred to the applicant for HIV primary care services. Describe the availability, accessibility, and the program's coordination/linkage with the CDC-funded HIV counseling, testing, referral, and prevention programs, if applicable. Please include information on TB and STI control programs. Describe the program's collaboration with other organizations involved in prevention for those already HIV positive.

Other federally funded services in your area: Describe the organization's collaboration with other primary health care services (if any exist in your area). These include publicly-funded Federally Qualified Health Centers, mental health and substance abuse treatment programs including those funded by SAMHSA, and research programs including those funded by NIH.

Because of space limitations, it is not necessary to include memoranda of agreement or understanding or contracts with other organizations in the application. Instead in **Attachment**

11, include a list of those organizations with which you have signed agreements with a brief description of what activities are covered. HRSA may request copies of those agreements and/or contracts as part of post-award administration.

- **WORK PLAN**

Division of Community HIV/AIDS Program (DCHAP) is recommending a **Work Plan Summary** format which simplifies the work plan to focus on measurable objectives for the required areas. Measurable objectives will be set for each area for Year One of the proposed project period. A table format is recommended with the objective areas listed on the left side, and the year of the project period across the top. Incorporate objectives for each sub-contractor into the Work Plan. Information previously included, such as action steps, evaluation methods, and person responsible will not be included here. You may wish to develop a more detailed work plan for internal use. Submit the Work Plan Summary as **Attachment 12**.

Please note that objectives for HIV testing under *Access to Care* and in *Comprehensive, Coordinated Primary HIV Medical Care* should refer to the number of unduplicated patients

who are receiving the service specifically funded under the Part C grant, rather than paid for by other funding sources, such as third party payers or other Ryan White HIV/AIDS Parts. A Part C eligible patient is one who may not have a third party payer for services. This includes patients who are *partially insured* (they may have insurance, such as Medicaid, for part of the year, and be uninsured the rest of the year). It also includes *underinsured* patients.

Underinsured status refers to those services not covered by insurance, which therefore can be covered by Part C. Underinsured also refers to other PLWHA for whom there is not an available provider who accepts the patient's insurance. For example: Medicaid pays for dental services but there are no dental providers in the service area who accept Medicaid.

For *Clinical Quality Management Program (CQM)*, refer to the entire clinic enrollment for HIV CQM activities not just Part C EIS patients. If subcontractors are providing clinical services, the objectives (as numbers and percentages) for CQM should include all providers. Include only those performance measures which reflect performance improvement activities that are planned during Year One, not all of the measures for which data will be collected. Most programs will have the capacity to do two to five performance improvement projects per year. Applicants are strongly encouraged to include Viral Load Suppression and a Retention in Care measure for performance improvement activities.

Work Plan Objectives:

The Work Plan should cover four major areas, as well as any additional measurable objectives which are important in implementing the HIV Primary Care Program. **As stated in the National HIV/AIDS Strategy (NHAS), demonstrate how the Work Plan addresses the NHAS goal: to increase access to care and optimize health outcomes for people living with HIV.** CDC Prevention activities and generic outreach activities should not be included. Include the following:

Access To Care

For the first year of the proposed project period, list:

- 1) The number of people to receive HIV counseling and testing funded by Part C
- 2) The anticipated number of HIV positive tests from the above;
- 3) The number of **new HIV infected** patients to be enrolled into primary HIV medical care, regardless of testing site.
- 4) The total number of HIV patients

Comprehensive, Coordinated Primary HIV Medical Care

For the first year of the proposed project period, for services **funded under the Part C** grant, list:

1. The total number of patients to be provided primary HIV medical care services funded by Part C. (Required)
2. The number of patients to be provided with mental health screening;
3. The number of patients to be provided with mental health treatment funded by Part C;
4. The number of patients to be provided with substance abuse screening;
5. The number of patients to be provided with substance abuse treatment funded by Part C;
6. The number of patients to be provided with Hepatitis B screening;
7. The number of patients to be provided with Hepatitis C screening;
8. The number of patients to be provided with care and treatment for Hepatitis C funded by Part C;
9. The number of patients to be provided with oral health care funded by Part C;
10. The number of patients to be provided with medical nutrition screening funded by Part C;

11. The number of patients to be provided with medical nutrition therapy by a registered dietitian or licensed nutritionist funded by Part C;
12. The number of patients to be provided with treatment adherence services provided by a qualified clinician funded by Part C;
13. The number of patients to be provided with medical case management by a trained professional, including a written plan of care which is updated regularly, funded by Part C;
14. The number of specialty referrals funded by Part C;
15. The number of patients for each of the support services you are providing using Part C funding to help individuals meet their HIV medical outcomes.

Clinical Quality Management Program (for entire clinic enrollment)

For the first year of the proposed project period, list two to three clinical performance indicators with a defined numerator and denominator. For example, Viral Load Suppression – the denominator is the total number of patients, regardless of age, with a diagnosis of HIV/AIDS and the numerator is the number of patients with a HIV-1 PCR RNA viral load less than 200 copies/ml at the last viral load test during the measurement year. Information about Retention in Care Measures (Gap, Medical Visit Frequency or Patients Newly Enrolled in Medical Care) can be found at:

http://www.incarecampaign.org/files/78588/in_care%20Campaign%20Measures.pdf .

▪ *RESOLUTION OF CHALLENGES*

This section is scored in Review Criterion 4: Impact. Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges.

New applicants for existing service areas should describe patients receiving primary medical care each year for the past three years as follows:

- 1) The total number of Patients,
- 2) The number of new Patients,
- 3) The total number of Patients with AIDS and with HIV non-AIDS,
- 4) The total number of Patients by race/ethnicity,
- 5) The total number of Patients by age ranges,
- 6) The total number of Patients by gender,
- 7) The total number of Patients by exposure category,
- 8) For youth ages 13-24 and older youth who have transitioned into adult care, list the numbers perinatally and behaviorally infected, and
- 9) The total number of Patients by insurance status and/or Part A or B funding for primary care services. List Private, Medicaid, Medicare, Other Public- specify by name/type, No Insurance, Part A, Part B, Part C.

- If a new applicant proposes to provide services in an area currently served by another grantee, please outline a transition plan of how existing patients, populations, and the scope of services will be provided.
- Describe the mechanisms by which the organization will ensure that Ryan White HIV/AIDS funding will be the payer of last resort and how Part C will not duplicate other funding received for medical care.
- Describe the average cost of care per patient for all patients for each service category: outpatient medical care, oral health, outpatient mental health treatment, outpatient substance abuse treatment, nutritional services, and specialty care.

Progress Narrative (Current Grantees): The progress narrative should summarize progress on meeting work plan objectives. The progress report will count against the 80-page limit of the application.

Progress narrative:

- Summarize the major accomplishments for the entire current project period, including program expansion activities, and describe the degree to which the objectives were achieved.
- Describe the factors that facilitated and hindered implementation of any of the project's goals, objectives and activities. Describe specific actions taken to overcome any barriers.
- Describe how consumers have been involved in the design, implementation, and evaluation of your program. Elaborate on the improvement(s) made in your program as a result of consumer involvement, including the number of consumers involved, their roles, and activities conducted.
- Describe the average cost of care per patient (all patients- not just Part C funded) for each service category: outpatient medical care, oral health, outpatient mental health treatment, outpatient substance abuse treatment, nutritional services, and specialty care.
- Describe how Ryan White HIV/AIDS funding is the payer of last resort and how Part C does not duplicate other funding received for medical care.
- Indicate whether one or more Part C EIS-specific site visits occurred during the most recent project period. For each site visit during the current project period, list the major program deficiencies cited, performance areas cited, and describe actions taken to correct deficiencies.
- Indicate whether the program has received separate technical assistance from HAB. Describe the focus of the technical assistance. What has changed as a result of the technical assistance?

Summary progress report on work plan objectives (submit as Attachment 13):

- The work plan progress summary should include a table, similar to the work plan summary described above, which shows the numerical objectives and results for **each** of the full calendar years of the current project period and the current calendar year to date (from 2009 through June 30, 2012, or later if data are available). Please note that prior work plans may have included the entire program, not just those patients receiving services funded by Part C.
- For each year of the project period and each objective listed under the work plan requirements, list the objective as a number and the actual result as a number. Provide individual sub-contractor performance data, as well whole program results.
- In a separate table include the following information for each of the calendar years of the most recent project period:
 - 1) The amount of Part C EIS funding received (per budget year)
 - 2) The amount of program income per budget year
 - 3) The total number of Patients,
 - 4) The number of new Patients,
 - 5) The total number of Patients with AIDS and with HIV non-AIDS
 - 6) The total number of Patients by race/ethnicity,
 - 7) The total number of Patients by age range,
 - 8) The total number of Patients by gender,

- 9) The total number of Patients by exposure category,
- 10) For youth ages 13-24 and older youth who have transitioned into adult care, list the numbers perinatally and behaviorally infected, and
- 11) The total number of Patients by insurance status and/or Part A or B funding for primary medical care services. List Private, Medicaid, Medicare, Other Public-specify by name/type, No Insurance, Part A, Part B, Part C.
- 12) The total number of Patients with medical care paid for by Part C.

▪ **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

This section is scored in *Review Criterion 3: Evaluative Measures*. In this section, describe the evaluation activities including quality management, as well as the information systems that support those activities. The HIV program's Quality Management Plan could be a useful resource.

Quality Management

- Infrastructure:
 - a. Describe the program's quality goals.
 - b. Describe the quality management infrastructure, including the key leaders and quality committee.
 - c. Describe the resources dedicated to quality management activities.
 - d. Describe the role of consumers in the Quality Management program.
 - e. Describe how the program monitors the effectiveness of the quality management infrastructure and the quality improvement activities.
- Performance Measurement:
 - a. Identify the performance measures, clinical and non-clinical, used by the program.
 - b. Describe the data collection plan and process (e.g. frequency, key activities, and responsible staff)
 - c. Describe the process for reporting and disseminating the performance measure results and findings.
 - d. Describe how data are used for quality improvement activities.
- Performance or Quality Improvement:
 - a. Describe the model for improvement used by the program, including tools (i.e. fishbone diagram, process mapping, etc.).
 - b. Discuss the areas for improvement your program identified over the last year.
 - c. Describe a (HIV) primary care performance improvement project that your program implemented in the past two years and describe the impact. Include a statement of the clinical issue, baseline data, interventions implemented, and follow-up data

Information Systems

The Ryan White HIV/AIDS Treatment Extension Act of 2009 has several new data requirements including the increased collection of medical information at the patient level of service using a unique identifier, the collection of data only for funded services (those provided through Ryan White HIV/AIDS Program funding), and data transmission to HRSA/HAB electronically.

Describe the current information system in use and its capacity to manage and report the required administrative and clinical data listed below. Do not provide specific data; rather, discuss how the information system that is used to manage, collect, and report the following data.

- Ryan White Services Report (Patient Level Data)
- The number of individuals provided early intervention services/primary care, counseling and testing, outreach, and case management services
- Demographic data on the patients receiving services, in total and for special funding initiatives
- Epidemiologic data on the population receiving services, including the extent of new TB infections, active cases, and multi-drug resistant-TB
- Exposure and diagnostic categories on the populations receiving services
- The number of HIV infected individuals and the CDC classification of their disease
- Track and report the extent to which the costs of HIV-related health care are paid by third party payers, and how those funds are used
- The average costs of providing each category of early intervention service/primary care as described above.

Describe the use of or any plans to implement an electronic health record (EHR).

The HIV/AIDS Bureau requires that any EHR or EHR component purchased, in whole or in part, with Federal funds meet the Office of the National Coordinator for Health Information Technology (ONC) requirements for certification. To improve the quality of clinical data collected, HAB further requires that any EHR or EHR component be configured to report appropriate clinical data electronically for HAB reporting (www.hrsa.gov/healthit/ehrguidelines.html).

Additionally, the Department of Health and Human Services has released standards for the meaningful use of Electronic Health Records (EHRs). This is supported by the Centers for Medicare and Medicaid (CMS) with an incentive program for both Medicaid and Medicare providers. Clinical care providers under Ryan White HIV/AIDS Parts A [2604 (g) (1)], B [2617 (b) (7) (F)] and C [2652 (b) (1)] are required to participate in state Medicaid programs. Consequently, it is expected that such grantees and providers will begin to use a certified EHR in the provision of care; <http://www.cms.gov/ehrincentiveprograms>.

▪ **ORGANIZATIONAL INFORMATION**

This section is scored in Review Criterion 5: Resources/Capabilities. In this section, describe the organization's capacity and expertise to provide primary care by describing the administrative, fiscal, and clinical operations. At minimum, the applicant should provide the following information:

- The mission of the organization. How does a Part C EIS project fit within the scope of this mission?
- The structure of the organization. Include in **Attachment 14** an Organizational Chart that clearly shows where the Part C EIS program fits within the applicant organization and how the program is divided into departments, the professional staff positions that administer those departments, and the reporting relationships.
- The organization's experience in providing HIV primary care services. Include primary medical and specialty care, mental health care, substance abuse services, and psychosocial support services. Also describe the organization's ability to respond to emerging populations with HIV.
- What systems are in place to ensure that the most recent HHS Guidelines, HIV/AIDS

- clinical standards and protocols are being followed?
- The organization's experience with the fiscal management of grants and contracts. What kind of accounting system is in place? What internal systems are used to monitor grant expenditures? How will the organization manage and monitor subcontractor performance and compliance with Part C EIS requirements?
 - The knowledge of and ability to implement culturally and linguistically appropriate services throughout the organization.
 - The status of the implementation of managed care contracts for persons with HIV. The discounted fee schedule that is being used and how it is implemented.
 - The annual cap on individual patient charges related to HIV services and how it is monitored.
 - How patient income is verified for purposes of the fee schedule and caps on charges. How program income is collected, tracked, and used to support the HIV program.
 - The organization's participation or intent to participate in the 340B Drug Pricing Program. If your organization purchases or reimburses for outpatient drugs, an assessment must be made to determine whether the organization's drug acquisition practices meet Federal requirements regarding cost-effectiveness and reasonableness (see 42 CFR Part 50, Subpart E, and OMB Circulars A-Section 340B of the Public Health Service Act), and the assessment shows that participating in the 340B Drug Pricing Program and its Prime Vendor Program is the most economical and reasonable manner of purchasing or reimbursing for covered outpatient drugs (as defined in section 340B). Failure to participate may result in a negative audit finding, cost disallowance or grant funding offset.

x. ***Attachments***

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Unless otherwise noted, attachments count toward the application page limit. **Each attachment must be clearly labeled.**

Attachment 1: Documentation of Medicaid and Medicare provider status and applicable facility licensure to provide clinical services. **Documentation for this application should be in the form of a table that identifies all providers' Medicaid and Medicare numbers and clinic licensure status, if applicable.** Include the Medicaid and Medicare provider number(s) for employed and contracted primary care and specialty care provider(s). If clinic licensure is not required in your jurisdiction, describe how that can be confirmed in State regulation or other information. This information is required each year. Official documentation may be required prior to an award being made or in the post-award period.

Attachment 2: Program-specific line item budgets, with a separate budget for each year of the proposed project period. Submit as a PDF document, not spreadsheet.

Attachment 3: If applicable, a copy of the current negotiated indirect cost rate agreement. This does not count toward the application page limit.

Attachment 4: Staffing Plan

Attachment 5: Job Descriptions for Vacant Key Personnel/Positions

Describe the affiliated duties for key vacant positions. Also describe the qualifications needed to fill the positions and the FTE associated with the position(s). Keep each to one page in length as much as is possible. You may find it helpful to supply this information in a table.

Attachment 6: Part C Additional Agreements and Assurances - Review the Part C EIS Additional Agreements and Assurances located in Appendix A. This document must be signed by the Authorized Organization Representative (AOR), scanned, and uploaded.

Attachment 7: Proof of non-profit status. This does not count toward the page limit.

Attachment 8: If applicable, justification for funding preference, which must be explicitly requested and justified in this attachment in order to receive it. The justification must demonstrate the existence of **ALL** of the specified factors for Qualification 1: Increased Burden in providing services, as described in section V.2, Review and Selection Process, Funding Preference, on pages 57-58. Applicants who qualify for preference under Qualification 1 can request an additional preference under Qualification a: Rural Areas or Qualification b: Underserved. The additional request must also be justified in this attachment.

Attachment 9: Map of Service Area, showing the location of other HIV service providers

Attachment 10: Letters from Part A and/or Part B. The letter must address why Part C EIS funds are necessary to address the needs described in your application. If you cannot obtain this letter, explain why.

Attachment 11: If applicable, list of all provider organizations who have signed major contracts and/or memoranda of agreement, with a brief description of the covered activities.

Attachment 12: Work Plan Summary, with measurable objectives for Year One of the proposed project period.

Attachment 13: Summary Progress Report on Work Plan Objectives - A summary progress report covering the entire current project period (3 years) is **required** for competing continuation applications.

Attachment 14: Organizational chart

Attachment 15: Optional attachments submitted by applicant. Please note that *all* optional attachments count toward the 80 page limit.

Letters of support other than those described in attachment 11 are not required. If you wish to submit them, include only letters of support which specifically indicate a commitment to the project/program (in-kind services, dollars, staff, space, equipment, etc.) Letters of agreement and support must be dated. List all other support letters on one page.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is **January 29, 2013 at 11:59 P.M. Eastern Time**. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically to the correct HRSA announcement number by the organization's Authorized Organization Representative (AOR) through Grants.gov and validated by Grants.gov on or before the deadline date and time.

Receipt acknowledgement: Upon receipt of an application, Grants.gov will send a series of email messages to document the progress of an application through the system.

1. The first will confirm receipt in the system;
2. The second will indicate whether the application has been successfully validated or has been rejected due to errors;
3. The third will be sent when the application has been successfully downloaded at HRSA; and
4. The fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods or hurricanes) or other disruptions of services, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

Late applications:

Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

4. Intergovernmental Review

Part C EIS is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. Application packages made available under this funding opportunity will contain a listing of States which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on States affected by this program and State Points of Contact may also be obtained from the Grants Management Specialist listed in the Agency Contact(s) section, as well as from the following Web site:
http://www.whitehouse.gov/omb/grants_spoc.

All applicants other than federally recognized Native American Tribal Groups should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the State's process used under this Executive Order.

Letters from the SPOC in response to Executive Order 12372 are due sixty days after the application due date.

5. Funding Restrictions

Applicants responding to this announcement may request funding for a project period of up to three (3) years, at no more than total FY 2012 award, before any offset or carryover adjustments,

per year as described in Appendix B. Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Funds under this announcement may not be used for the following purposes:

- Part C EIS funds cannot be used to pay for inpatient services, hospice, residential treatment, clinical research, nursing home care, cash payments to Patients, or purchasing or improving real property.
- Ryan White HIV/AIDS Program funds cannot be used for Syringe Services programs.
- Funds awarded under this announcement may not be used for the following purposes: research, fundraising expenses, lobbying activities and expenses, pre-award costs, foreign travel, or construction, unless it is minor alterations to an existing facility, to make it more suitable for the purposes of the grant program. In such case, prior authorization must be sought. Other non-allowable costs can be found in the Cost Principles located in Title 2 of the Code of Federal Regulations available online at http://www.access.gpo.gov/nara/cfr/waisidx_10/2cfrv1_10.html#1.
- No more than 10%, including planning and evaluation of the grant, may be expended for administrative expenses.
- At least 50% of the grant must be expended for EIS Services.
- At least 75% of the grant, after reserving funds for Clinical Quality Management and Administration, must be expended for Core Medical Services.
- It is a program expectation that grant funding spent on Clinical Quality Management will be kept to a reasonable level, consistent with Parts A and B.
- Payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service
 - Under any State compensation program, insurance policy, Federal or State health benefits program, or
 - By an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).

Salary Limitation: The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts under a HRSA grant or cooperative agreement.

Per Division F, Title V, Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011 (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body,

except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Per Division F, Title V, Section 523 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are **required** to submit **electronically** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at <http://www.grants.gov>. When using Grants.gov applicants will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that organizations **immediately register** in Grants.gov and become familiar with the Grants.gov site application process. Applicants that do not complete the registration process will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary to complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with the System for Award Management (SAM)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's SAM "Marketing Partner ID Number (M-PIN)" password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials and FAQs are available on the Grants.gov web site at <http://www.grants.gov>. Assistance is also available 24 hours a day, 7 days a week (excluding Federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline. Therefore, an organization is urged to submit an application in advance of the deadline. If an application is rejected by Grants.gov due to errors, it must be corrected and resubmitted to Grants.gov before the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadline.

Applications will be rejected and not available for review (see below) if the application is late, and /or in excess of the page limit. In addition, an application may not be considered if it does not completely address all of the sections clearly outlined above.

If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant’s last validated electronic submission prior to the Grants.gov application due date as the final and only acceptable application.

Tracking an application: It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking an application can be found at <https://apply07.grants.gov/apply/checkApplStatus.faces>. Be sure the application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points. Funding levels will be reviewed in reference to level of effort, progress, and performance described in this application. For current Part C EIS grantees, past performance in meeting legislative requirements and program expectations will be taken into account regarding continuation of funding and the level of funding awarded.

Review Criteria are used to review and rank applications. The Part C Early Intervention Services Program has six (6) review criteria:

Criterion 1: Need	10 points
Criterion 2: Response	35 points
Criterion 3: Evaluative Measures	10 points
Criterion 4: Impact	20 points
Criterion 5: Resources/Capabilities	10 points
Criterion 6: Support Requested	15 points
TOTAL	100 points

Criterion 1: NEED (10 points)

This section corresponds to the Needs Assessment and Introduction sections of the application.

- The extent to which the applicant provides clear and reliable data showing an **increased** burden of HIV infection in the service area. **(up to 2 points)**
- The extent to which the applicant clearly describes the target population and **the need** for HIV-related health services in this population. The extent to which the applicant **addresses the NHAS goal: to reduce HIV-related health disparities. (up to 2 points)**
- The extent to which the applicant **documents the public funding sources for HIV prevention and care in the proposed service area. (up to 2 points)**
- The extent to which the applicant identifies unmet need, gaps in service and barriers to care. For example, if a service area is lacking access to oral health care, then this is an unmet need and should be outlined in this section. **(up to 2 points)**
- The extent to which the information in the application shows a need for medical care paid by Part C, for Patients not covered by other Ryan White HIV/AIDS Parts or by other public/private insurance for the same service. **(up to 2 points)**

Criterion 2: RESPONSE (35 points)

This section corresponds to the Methodology (Sections 1-6 and the Work Plan) section of the application.

- Evidence of a sound system of HIV Counseling, Testing, Referral, Partner Counseling, and Linking to Care, which is targeted to those at high risk for HIV infection. If the applicant indicates that MAI funding has been received, the strength of the outreach, enrollment and retention in care for targeted groups must be reflected. **The extent to which the applicant addresses the NHAS goals: (1) to reduce the number of people who become infected with HIV, and; (2) to increase access to care and optimize health outcomes for people living with HIV. (up to 5 points)**
- Overall, the extent to which the applicant documents the ability of the organization to provide, internally and/or by contract, the full comprehensive continuum of HIV care, funded under the grant. The strength of the medical evaluation and clinical care systems (such as periodic medical evaluations, CD4 monitoring, viral load testing, antiretroviral therapy, prophylaxis and treatment of opportunistic infections, and malignancies). Evidence of adequate support for laboratory and pharmacy services, plans for staff education, and the involvement of consumers in decisions regarding their care. The extent to which the applicant describes a sound policy for after-hours and weekend coverage for urgent or emergency medical and dental care needs. The effectiveness of formal systems in place for referrals of individuals to health and support services that are not directly provided by the applicant. Evidence of mechanisms to follow-up on referrals and receive feedback from the providers of health and support services to which patients are referred. Also include how gaps in services and unmet needs are to be addressed. The extent to which the applicant **addresses the NHAS goal: to increase access to care and optimize health outcomes for people living with HIV. (up to 15 points)**
- The extent to which the applicant documents the availability and access to other core medical services, including outpatient oral health, treatment adherence, mental health/substance abuse outpatient counseling and nutritional counseling . The extent

to which HIV prevention services are incorporated into medical care. **(up to 5 points).**

- The strength of the work plan summary as evidenced by measurable objectives that reflect, access to care, the comprehensive continuum of HIV care, quality improvement, and consumer involvement funded under the grant. **(up to 10 points)**

Criterion 3: EVALUATIVE MEASURES (10 points)

This section corresponds primarily to the Evaluation and Technical Support Capacity section of the application.

- The strength of the quality management infrastructure, including the key leaders and quality committee, and frequency of meetings. The appropriateness of the role of consumers in the Quality Management program **(up to 2 points)**
- The appropriateness of clinical indicators used to measure performance and a clear indication of how results have prompted change in the delivery of clinical care. The extent to which the applicant describes how data are used for quality improvement activities, including an example of an HIV primary care quality improvement project that the program implemented. The extent to which the applicant addresses the NHAS goal: to increase access to care and optimize health outcomes for people living with HIV. **(up to 4 points)**
- The extent to which the applicant demonstrates the ability to comply with reporting requirements of the program. The strength of data collection plan and process (e.g., frequency, key activities, and responsible staff). The strength of the process for reporting and disseminating the results and findings. **(up to 4 points)**

Criterion 4: IMPACT (20 points)

This section corresponds to the overall application, Resolution of Challenges, Evaluation and Technical Support Capacity section (Quality Management) the Methodology (Section 7) and Attachments sections of the application.

- If a **current** grantee, the extent to which the applicant demonstrates adequate progress on the project period work plan, in the narrative and in the Summary Progress Report **Attachment 13**). The extent to which the applicant has successfully implemented a Part C EIS program that meets program requirements. The appropriateness of the response to any site visit findings (e.g., major program deficiencies, performance areas and corrective actions). **(up to 10 points)**
- **Or**, if a **new** applicant, the level of demonstrated ability to provide HIV medical care demonstrated by the applicant. The applicant's demonstrated ability to meet Part C requirements. The soundness of the applicant's provided service transition plan, demonstrating how it will serve and improve services to, the existing patients, populations, scope of services and service areas currently served by the grantee they intend to replace. The extent to which the applicant describes appropriate activities, timelines and coordination of strategies to minimize any potential disruption of service. **(up to 10 points)**

- The extent to which the applicant, whether current or new, documents linkages, coordination and collaboration with other programs and providers, such as Part A, Part B, Part D, HOPWA, CDC funded counseling and testing programs, prevention programs, TB and STI control programs, other Ryan White HIV/AIDS Program funded programs, as well as Community Health Centers and programs funded by the NIH and SAMHSA. **The extent to which the applicant addresses the NHAS goal: to increase access to care and optimize health outcomes for people living with HIV. (up to 7 points)**
- The extent to which the applicant, whether current or new, accurately describes the total number of Patients and the number of new Patients receiving primary medical care in each of the last three years. The extent to which the applicant provides information about service and demographic information. **(up to 3 points)**

Criterion 5: RESOURCES/CAPABILITIES (10 points)

This section corresponds to the Staffing Plan, Organizational Information, and Attachments sections of the application.

- The extent to which project personnel are qualified by training and/or experience to provide early intervention services under the grant. The appropriateness of the staffing plan (includes the full range of information requested, combining the elements of job descriptions and biographical sketches). The strength of the systems in place to ensure that the most recent HIV/AIDS clinical standards and protocols will be followed. **(up to 2 points)**
- Evidence of the organization's ability to implement the proposed project. The strength of the organization's mission, structure and experience which support the provision of HIV Primary care services as evidenced by the clinic licensure information and organizational chart. **(up to 3 points)**
- Overall, the strength of the organization's fiscal and Management Information Systems (MIS) capacity to manage this grant, and meet program requirements including monitoring grant expenditures, a discounted fee schedule, annual caps on patient charges, and collecting, tracking and using program income to support the HIV program. If applicable, the applicant's demonstration of the ability to manage and monitor subcontractor performance and compliance with Part C EIS requirements **(up to 3 points)**
- The appropriateness of the level of involvement of consumers in the development, implementation, and evaluation of the Part C EIS program. Evidence of the applicant's knowledge of and ability to implement culturally and linguistically appropriate services **(up to 2 points)**

Criterion 6: SUPPORT REQUESTED (15 points)

This section corresponds to the budget documents, Resolution of Challenges/Progress Report and the Attachment sections of the application.

- The appropriateness of the requested funding level for each year of the three-year project period in comparison to the level of effort, performance, and total number of patients served. The extent to which the gaps in services identified in the Need section

are addressed in the narrative and budget. The reasonableness of the average cost of care for each service category. For all applicants, the number of new and ongoing patients, the number of patients with AIDS, and the number of patients not covered by other Ryan White Parts or public/private insurance for the same service will be considered. For current grantees, reviewers will consider progress in achieving their objectives. For new applicants, reviewers will consider the numbers reported in the resolution of challenges section and the objectives in the work plan summary. **(up to 8 points)**

- The extent to which the budget allocates resources to ensure that at least **50 percent** of funds are for the provision of early intervention services, as described in the legislation: laboratory testing, clinical and diagnostic services, periodic medical evaluations, therapeutic measures, and referrals for health and support services. Evidence that the amount of licensed medical provider time is reasonable for the number of patients and whether the supportive positions are in reasonable proportion to the provider time requested. The extent to which the budget allocates resources to ensure that at least **75 percent** of funds are for the provision of core medical services, after funds are reserved for clinical quality management and administration. The extent to which financial resources for clinical quality management are allocated at a reasonable level. The extent to which the budget adheres to the **10 percent** limit on administrative costs. The extent to which the applicant **addresses the NHAS goal: to increase access to care and optimize health outcomes for people living with HIV. (up to 5 points)**

- The reasonableness of the 424A Section B and program-specific line item budget for each budget period in the proposed project period. The clarity of the presented budget justification narrative that fully explains each line item. For subsequent budget years, the extent to which the applicant highlights changes from Year One or clearly indicates that there are no substantive changes from Year One. The extent to which the line item, budget justification narrative, and 424A match. **(up to 2 points)**

As part of this review, reviewers will be asked to recommend the amount of funding the grantee should receive, based on the scoring criteria above.

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in Section V. 1. Review Criteria of this funding opportunity announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. In the event that only one application is received for a given service area, the

HRSA/HIV/AIDS Bureau will conduct a comprehensive internal objective review of the application in lieu of an external objective review. HRSA reserves the right to review fundable applicants for compliance with HRSA program requirements through reviews of site visits, audit data, Ryan White Service Reports, allocation and expenditure reports, FFR, or other performance reports, as is applicable. The Bureau Staff uses knowledge of state and local funding resources to prioritize funding of applicants with the greatest need and prioritizes the applications which have a direct model of comprehensive HIV care. The results of this review may impact final funding decisions. All awarded programs will receive a site visit to confirm the execution of the work plan and to ensure compliance with legislative requirements.

Funding Preferences

The Ryan White HIV/AIDS Program establishes a funding preference for some applicants, consistent with section 2653 of the PHS Act. Applicants qualified for the preference will be placed in a more competitive position among applications for funding. Applications that do not qualify for a funding preference will be given full and equitable consideration during the review process. The law provides that a funding preference be granted to any qualified applicant that specifically requests the preference and meets the qualification for the preference as follows: **(Please note: if Qualification 1 is not met, then Qualifications a and b are not applicable.)**

Qualification 1: Increased Burden

An applicant can request a funding preference if they demonstrate an increase in the burden of providing services regarding HIV disease, over the past two years and for the geographic service area for the applicant. The applicant must demonstrate the existence of **ALL** the following factors: the number of cases of HIV/AIDS; the rate of increase of HIV/AIDS cases; the lack of availability of early intervention services from all sources; the number and rate of increase of cases of other sexually transmitted diseases, tuberculosis, drug abuse, co-infection with HIV/AIDS and hepatitis B or C; the lack of primary health providers other than the applicant; the distance between the applicant's service area and a community that has an adequate level of availability of appropriate HIV-related services, and the length of time required for patients to travel that distance.

Qualification a: Rural Areas

Of applicants who qualify for preference under Qualification 1, an applicant can also request a funding preference if they provide services in rural areas (outside urbanized areas and urban clusters as described by the U.S. Census Bureau).

Qualification b: Underserved

Of applicants who qualify for preference under Qualification 1, an applicant can also request funding preferences if they provide services in areas that are underserved with respect to Early Intervention Services. The Ryan White HIV/AIDS Program funds Early Intervention Services under Parts A, B and C. Applicants requesting a funding preference due to Early Intervention Services being underserved in a particular area must demonstrate that the area is underserved, including funding received under Parts A, B and C, in order to qualify.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of July 1, 2013.

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The NoA sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, the Notice of Award is sent to the applicant's Authorized Organization Representative, and is the only authorizing document. It will be sent prior to the start date of July 1, 2013.

2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 [Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations](#) or 45 CFR Part 92 [Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments](#), as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NOA).

Non-Discrimination Requirements

To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see <http://www.hhs.gov/ocr/civilrights/understanding/index.html>. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P.L. 88-352, as amended and 45 CFR Part 80). In some instances a recipient's failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html> to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.

Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.html>.

Smoke-Free Workplace

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Cultural and Linguistic Competence

HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA-funded programs embrace a broader definition to incorporate diversity within specific cultural groups including but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. Additional cultural competency and health literacy tools, resources and definitions are available online at <http://www.hrsa.gov/culturalcompetence> and <http://www.hrsa.gov/healthliteracy>.

Healthy People 2020

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at <http://www.healthypeople.gov/>.

Health IT

Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:

- [Health Information Technology \(HHS\)](#)
- [What is Health Care Quality and Who Decides? \(AHRQ\)](#)

3. Reporting

The successful applicant under this funding opportunity announcement must comply with the following reporting and review activities:

a. **Audit Requirements**

Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default.

b. **Payment Management Requirements**

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to <http://www.dpm.psc.gov> for additional information.

c. **Status Reports**

1) **Federal Financial Report.** The Federal Financial Report (SF-425) is required according to the following schedule: <http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf>. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the NOA.

2) **Progress Report(s).** The awardee must submit a progress report to HRSA on an annual basis. Submission and HRSA approval of grantee Progress Report(s) triggers the budget period renewal and release of subsequent year funds. Further information will be provided in the NOA.

3) **Final Report.** A final report is due within 90 days after the project period ends. The final report collects program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee's overall experiences over the entire project period. The final report must be submitted on-line by awardees in the Electronic Handbooks system at <https://grants.hrsa.gov/webexternal/home.asp>.

4) **Tangible Personal Property Report.** If applicable, the awardee must submit the Tangible Personal Property Report (SF-428) and any related forms. The report must be submitted within 90 days after the project period ends. Awardees are required to report all federally-owned property and acquired equipment with an acquisition cost of \$5,000 or more per unit. Tangible personal property means property of any kind, except real

property, that has physical existence. It includes equipment and supplies. Property may be provided by HRSA or acquired by the recipient with award funds. Federally-owned property consists of items that were furnished by the Federal Government. Tangible personal property reports must be submitted electronically through EHB. More specific information will be included in the NOA.

5) Submit the annual **Ryan White HIV/AIDS Program Services Report (RSR)**, which consists of grantee, service provider, and patient level reports via the HRSA Electronic Handbooks.

6) Submit an **Allocation Report**, due 60 days after the start of the budget period, and an **Expenditure Report**, due 90 days after the end of the budget period. These reports account for the allocation and then expenditure of all grant funds according to the specific core medical services, support services, clinical quality management, and administration. Data for these reports will be uploaded to a secure HRSA server via the HRSA Electronic Handbooks. The forms to report this information for all parts of the Ryan White HIV/AIDS Program were extended by the Office of Management and Budget on March 21, 2011, OMB Number 0915-0318.

7) Submit, every two (2) years, to the lead State agency for Part B, audits consistent with Office of Management and Budget Circular A-133, regarding funds expended in accordance with this title and include necessary patient level data to complete unmet need calculations and the Statewide Coordinated Statements of Need process.

d. Transparency Act Reporting Requirements

New awards (“Type 1”) issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of \$25,000 or more in Federal funds and executive total compensation for the recipient’s and subrecipient’s five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at <http://www.hrsa.gov/grants/ffata.html>). Competing continuation awardees, etc. may be subject to this requirement and will be so notified in the NOA.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Olusola Dada
Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 12-A07
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-0195
Fax: (301) 443-9810

Email: ODada@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Hannah Endale, Chief, Central Region Branch
Division of Community HIV/AIDS Programs
HRSA, HIV/AIDS Bureau
5600 Fishers Lane, #9-74
Rockville, MD 20857
Tel. (301) 443-0493
Fax (301) 443-1839
E-mail: HEndale@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: <http://grants.gov/iportal>

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting information in HRSA's EHBs, contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

VIII. Other Information

Technical Assistance

All applicants are encouraged to participate in a technical assistance (TA) call for this funding opportunity. HAB/DTCD/AETCHEB is sponsoring a pre-application technical assistance (TA) webinar on December 11, 2012 from 2:00 PM- 4:00 PM Eastern Time to assist potential applicants in preparing applications that address the requirements of this funding announcement. Participation in a pre-application TA webinar is optional. For more information on the webinar and to register please go to: <http://careacttarget.org/events>.

Date and Time: December 11, 2012 from 2 PM-4 PM Eastern Time.
Direct Link to Webinar: <https://hrsa.connectsolutions.com/partcJuly/>
Participant Phone Number: 866-700-0701
Participant Pass code: 345123

IX. Tips for Writing a Strong Application

HRSA has designed a technical assistance webpage to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant. The website can be accessed online at: <http://www.hrsa.gov/grants/apply/index.html>.

In addition, a concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at: <http://dhhs.gov/asfr/ogapa/grantinformation/apptips.html>.

Appendix A: Additional Agreements & Assurances

Ryan White HIV/AIDS Treatment Extension Act of 2009, Part C EIS

The authorized representative of the applicant must include a signed and scanned original copy of the attached form with the grant application. This form lists the program assurances which must be satisfied in order to qualify for a Part C grant.

NOTE: The text of the assurances has been abbreviated on this form for ease of understanding; however, grantees are required to comply with all aspects of the assurances as they are stated in the Act.

I, the authorized representative of _____ in applying for a grant under Part C of Title XXVI, Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009, P.L. 111-87, 42 U.S.C. 300ff-51 - 300ff-67, hereby certify that:

I. As required in section 2651:

A. Grant funds will be expended only for providing core medical services as described in subsection (c), support services as described in subsection (d) and administrative expenses as described in section 2664(g)(3).

B. Grant funds will be expended for the purposes of providing, on an outpatient basis, each of the following early intervention required services:

1. Counseling individuals with respect to HIV disease in accordance with section 2662;
2. Testing to confirm the presence of HIV infection; to diagnose the extent of immune deficiency; to provide clinical information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;
3. Other clinical preventive and diagnostic services regarding HIV disease, and periodic medical evaluations of individuals with the disease;
4. Providing the therapeutic measures described in 2 above; and
5. Referrals described in section 2651(e)(2);

C. Grantee will expend not less than 50% of grant funds awarded for activities described in 2-5 above.

D. After reserving funds for administration and clinical quality management, grantee will use not less than 75% of the remaining grant funds to provide core medical services that are needed in the area involved for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

E. Each of the early intervention services in A. will be available through the applicant entity, either directly or through public or nonprofit private entities, or through for-profit entities if such entities are the only available provider of quality HIV care in the area.

F. A small proportion of grant funds may also be expended to provide the support services that are needed for individuals with HIV/AIDS to achieve their medical outcomes.

II. As required under section 2652(b), all providers of services available in the Medicaid State plan must have entered into a participation agreement under the State plan and be qualified to receive payments under such plan, or receive a waiver from this requirement.

III. As required under section 2654(a): Provisions of services to persons with hemophilia will be made and/or coordinated with the network of comprehensive hemophilia diagnostic and treatment centers.

IV. As required under section 2661(a): The confidentiality of all information relating to the person(s) receiving services will be maintained in accordance with applicable law.

- V. As required under section 2661(b): Informed consent for HIV testing will be obtained.
- VI. As required under section 2662: The applicant agrees to provide appropriate counseling services, under conditions appropriate to the needs of individuals.
- VII. As required under section 2663: All testing that is conducted with Ryan White HIV/AIDS Program funds will be carried out in accordance with sections 2661 and 2662.
- VII. As required under section 2664(a)(1)(C) Information regarding how the expected expenditures under the grant are related to the planning process for localities funded under part A (including the planning process described in section 2602) and for States funded under part B (including the planning process described in section 2617(b)) will be submitted.
- IX. As required under section 2664(a)(1)(D) A specification of the expected expenditures and how those expenditures will improve overall client outcomes, as described in the State plan under section 2517(b) will be submitted.
- X. As required under section 2664(a)(2): A report to the Secretary in the form and on the schedule specified by the Secretary will be submitted.
- XI. As required under section 2664(a)(3) Additional documentation to the Secretary regarding the process used to obtain community input into the design and implementation of activities related to the grant will be submitted.
- XII. As required under section 2664(a)(4) Audits regarding funds expended under Part C will be submitted every 2 years to the lead State agency under section 2617(b)(4) and will include necessary client level data to complete unmet need calculations and the Statewide Coordinated Statements of Need process.
- XII. As required under section 2664(b): To the extent permitted under State law, regulation or rule, opportunities for anonymous counseling and testing will be provided.
- XIV. As required under section 2664(c): Individuals seeking services will not have to undergo testing as a condition of receiving other health services.
- XV. As required under section 2664(d): The level of pre-grant expenditures for early intervention services will be maintained at the level of the year prior to the grant year.
- XVI. As required under section 2664(e): A sliding fee schedule with limits and conditions specified in section 2664 (e) will be utilized.
- XVII. As required under section 2664(f): Funds will not be expended for services covered, or which could reasonably be expected to be covered, under any State compensation program, insurance policy, or any Federal or State health benefits program (except for a program administered by or providing services of the Indian Health Service); or by an entity that provides health services on a prepaid basis.
- XVIII. As required under section 2664(g): Funds will be expended only for the purposes awarded, such procedures for fiscal control and fund accounting as may be necessary will be established, and not more than 10 percent of the grant will be expended for administrative expenses, including planning an evaluation, except that the costs of a clinical quality management program may not be considered administrative expenses for the purposes of such limitation.
- XIX. As required under section 2667: Agreement that counseling programs shall not be designed to promote, or encourage directly, intravenous drug abuse or sexual activity, homosexual or heterosexual; shall be designed to reduce exposure to and transmission of HIV/AIDS by providing accurate information; shall provide information on the health risks of promiscuous sexual activity and intravenous drug abuse; and shall provide information on the transmission and prevention of hepatitis A, B, and C, including education about the availability of hepatitis A and B vaccines and assisting patients in identifying vaccination sites.
- XX. As required under section 2681: Assure that services funded will be integrated with other such services,

coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

XXI. As required under section 2684: No funds will be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature: _____ Date: _____

Title: _____

Appendix B: Service Areas

These service areas have project periods ending **June 30, 2013**, and are up for competition for **July 1, 2013**. New proposals to replace existing grantees are expected to cover the entire service area of the existing grantee. Each grantee's service area is listed separately.

Service areas for project periods ending June 30, 2013

Grantee Name	City, State	Funding Level	Service Areas
T.H.E. Clinic	Los Angeles, CA	\$350,979	Los Angeles County
District Four Health Services	LaGrange, GA	\$454,871	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson
Harbor Health Services Inc.	Dorchester, MA	\$406,556	Dorchester, South Boston, North Quincy, and Hyannis, Cape Cod
Family Health Center of Worcester, Inc.	Worcester, MA	\$603,475	Worcester
Detroit Community Health Connection	Detroit, MI	\$704,650	Wayne County
City of Tutwiler	Tutwiler, MS	\$395,159	Bolivar, Coahoma, Leflore, Marshall, Panola, Quitman, Tate, Tunica
Hoboken Municipal Hospital Authority	Hoboken, NJ	\$692,332	Hudson County
Mt. Sinai Hospital	New York, NY	\$388,000	New York City
University of Pittsburgh	Pittsburgh, PA	\$1,086,074	Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Somerset, Washington, Westmoreland

Comprehensive Care Center	Nashville, TN	\$706,990	Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, De Kalb, Dickson, Fentress, Giles, Hickman, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, Wilson counties
Centra Health, Inc.	Lynchburg, VA	\$220,267	Amherst, Appomattox, Bedford City, Campbell, Pittsylvania counties